

The American Practitioner.

MAY, 1885.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Communications.

A CASE OF TRAUMATIC EPILEPSY CURED BY THE USE OF THE TREPHINE.

BY J. R. WEIST, M. D.

The very valuable paper of Dr. W. T. Briggs, of Nashville, Tenn., on the "Surgical Treatment of Epilepsy," read at the meeting of the American Surgical Association in 1884, and published in Volume II of the Transactions of the Association, having brought the question of the propriety of trephining for the cure of epilepsy again prominently before the profession, the following brief report of a successful case may be of some interest:

Frank Mitchell, nineteen years old, was struck at the upper and outer margin of the right frontal eminence by a number one shot, January 12, 1878. He was brought to me soon after the injury. The small opening in the scalp was enlarged and the flattened shot found slightly imbedded in the bone. The shot was removed, some headache was complained of for a few days, but the wound soon healed. About two weeks after the injury, while riding in a wagon, he had a severe epileptic seizure; soon after this the wound opened, and did not entirely close for about five months. During this period frequent headaches were

complained of, and several small scales of bone were removed. About a year after the accident a second epileptic seizure occurred, and attacks followed, at first every two or three weeks, gradually increasing in frequency during four years. Then for two years, and up to the time of operation, they occurred two or three times per week, generally of severe character. He was still subject to frequent headaches, worse on the right side. The epileptic seizures were preceded by increased pain in the head, and a tendency to turn the head to the right. No special impairment of the mental functions was observed. The slightly depressed cicatrix, about half an inch in diameter, was tender. On April 6, 1885, assisted by a number of medical gentlemen, a triangular flap was raised over the seat of injury, and a button of bone three fourths of an inch in diameter removed by the trephine. The cicatricial tissue of the scalp was found adherent to and to pass through a small opening in the bone, which was very thin, and attached to the dura mater. After the button was removed, it was found that the center-pin of the trephine, which had been protruded but very slightly, had not been placed on bone, but on cicatricial tissue, and it is probable that the point had penetrated the dura mater. A drainage-tube was placed in the wound, the flap held in place by two or three sutures, and a light compress applied. The next morning the patient was doing well, but it was observed that the dura mater was raised through the opening above the level of the bone and pulsated strongly. These phenomena had disappeared on the next day, when pus escaped freely from beneath the flap. On the third day the pulse beat rapidly, pain in the right side of head was complained of, and slight symptoms of paralysis appeared on the right side of the face and in left arm and leg. These unfavorable symptoms increased. The pulse and respiration became slow, with complete motor and partial sensory paralysis on the left side, with marked comatose symptoms. Discharges involuntary. All the signs of cerebral abscess were present, but operative procedures were delayed because of its apparent location. The motor centers of the arm and leg are about two

inches posterior to the opening in the skull, and they were evidently involved. Finally, thirteen days after the operation Dr. Bond, who had charge of the case during my absence from the city, freely divided the dura mater and brain through the opening already made in the skull; considerable pus was discharged, and in five hours motion appeared in left leg and arm. Pus continued to discharge for several days, then serum for a few days, when the flow ceased, and the wound was allowed to close. In a few days all unfavorable symptoms save a slight headache disappeared. The patient was discharged from the hospital and his condition still remains good. He has had no epileptic seizure since the operation; and, having been free of an attack longer than at any time during six years, there is reasonable ground for the hope that a cure of the epilepsy has been effected. He will be kept for some time on the use of sodium bromide.

By giving attention to the facts herein recited regarding this case future errors may be avoided. Probably the center-pin of the trephine wounded the dura mater; this was followed by an effusion of blood beneath it, shown by the pulsating tumor, and inflammation and suppuration. By using the trephine through an opening in a disk of wood or leather the use of the center-pin would not have been necessary. Perfect drainage was not provided for, and another preventable cause of inflammation of the membranes and brain allowed to be present. It would perhaps have been better practice to have entirely removed a portion of the scalp corresponding to the opening in the skull. In this way perfect drainage would have been effected, and as the dura mater would have been under direct observation, it would have been incised as soon as made prominent by the blood or pus beneath.

Thus through our mistakes may we acquire wisdom.

RICHMOND, IND.

POST-PARTUM HEMORRHAGE.*

BY JAMES F. HIBBERD, M. D.

Last year I had the honor to present to this society a paper on Post-partum Hemorrhage, which excited an earnest and protracted debate—that I am fain to hope did some good—by bringing up to our professional vision with great distinctness two very important points in obstetrical practice, viz., that there are certain principles underlying the scientific management of post-partum hemorrhage, and that he only is a competent and safe obstetrician who, in advance of his meeting with a case of this hemorrhage, is thoroughly conversant with these principles, it being manifest that after the advent of the hemorrhage there is no time to hunt up the proper practice nor send for counsel. Whatever is necessary to save the patient must be done at once. A delay to do the right thing for even a few minutes may be fatal to the patient, and to do the wrong thing promptly or deliberately may be equally disastrous.

It is these considerations that give me warrant to present the subject afresh at the first opportunity; and, furthermore, the diverse views of the proper management of these cases proclaimed by the polemics last year seem to make it judicious to keep the subject agitated until our professional minds arrive at something approaching unanimity as to the best line of procedure, or otherwise establish the fact that several lines are equally feasible and reliable.

My position last year was that the dogma, so earnestly promulgated by the late Prof. Meigs in these cases, "Turn out that clot," was surely not a safe rule of action in all cases, and possibly applicable to only a small minority of them, and after the interchange of sentiment and experience by the members on that occasion I was confirmed in that position.

*Read before the Indiana State Medical Society, May 13, 1885. The paper to which the author refers appeared in the June number, 1884, of the *American Practitioner*.

Although it was not distinctly stated in my former essay, that it was never necessary to insert the hand into the uterus for the sole purpose of clearing it of the clots of hemorrhage after childbirth, such a conclusion was a fair inference from the tenor of the article, and I felt justified in the idea from the fact that in over forty years of general practice, with a full proportion of obstetrical engagements, I had never met with such a necessity. The one condition that would theoretically demand such an interference is when the uterus is filled with blood and the hemorrhage continuing, and the attendant wholly unable to secure contraction of the womb by external manipulation or otherwise.

Holding that the contraction of the womb is the legitimate and natural mode of arresting the hemorrhage, by bending and occluding the sinuses, my thought was that if the contraction could not be commanded by other means, the hand should be inserted and the clot turned out. But it appears that the uterus may refuse to contract, and still the best practice may be not to turn out the clot.

In the Medical News (Philadelphia) of October 18, 1884, there is an editorial reciting the points of my last year's paper in a spirit of commendation, and closing with particulars of a case reported by Lumpe, in a recent number of the *Archiv. für Gynäkologie*.

In Lumpe's case, "after the delivery of the child, the uterus did not contract at all, but remained relaxed like a leather bag, and its contour could not be felt through the abdominal walls. The placenta was detached, but still there was no contraction of the uterus; yet the bleeding was not excessive. More blood was discharged than usual, but gradually the flow ceased, and I felt in the cervix coagula. I believe it would have been most improper for me to have removed the blood coagula from the uterus and the vagina, for only the exceptional coagulability of the blood saved the woman from flooding."

With this additional testimony we must surely see that there can not be an unvarying routine of acts to be gone through with in every case of post-partum hemorrhage, but that in this, as in

all other disorders, it is indispensable that the scientific attendant first clearly comprehends the nature of the difficulty he has to contend with, and then as fully understands the principles of the means of relief applicable to the case.

To illustrate another point in practice in cases of post-partum hemorrhage, I submit the following :

I was called at 1 o'clock P. M. August 21, 1884, to see J. G. M., in labor with her first child. She first felt pain at 4 A. M. of the same day, and the labor progressed smoothly to 3 P. M., when the first stage was completed, and I ruptured the membranes, giving exit to a moderate quantity of liquor amnii. The second stage of labor was completed at 4:30 by the delivery of a vigorous boy, and the third stage at 4:50, the delivery of the placenta being assisted somewhat by my fingers. The uterus contracted promptly under massage, but showing a slight disposition to relax, and the patient complaining of more than usual pain after normal first labors, I gave her ten minims of Squibb's fluid extract of ergot and the tenth of a grain of morphia. In a few minutes all appeared to be quiet, and soon after I left the lying-in chamber, and was adjusting my cuffs in another room when the nurse notified me that she thought the patient was bleeding too much, and on returning to the bedside I found the patient in great pain, referred to the left iliac region in front and the sacrum in the rear, and that the fundus of the uterus had risen to the umbilicus. I immediately administered twenty minims of fluid extract ergot and a tenth grain of morphia, and resorted to massage of the uterus through the abdominal wall, which induced contraction without reducing its size or position. The patient was lying on her back, now complaining of still greater pain, and I had her turned to her left side, the position in which she was delivered of both child and secundines. The only effect of this turning over was to transfer the pain from the left to the right iliac region, it and the sacrum pain both now so intensified that the victim declared the suffering much greater than at the close of the second stage of her labor. This pain was located where I had not before known in a primi-

para, and it was of a severity I had not before witnessed in a primipara. It amounted to agony. And added to this the uterus was contracting powerfully under manipulation at regular short intervals, but was not at all reduced in size. The pulse had become frequent and feeble, and the prolabia had lost some of their freshness, but no blood was passing the vulva. My diagnosis was that the womb was filled with blood, which the contractions, strong as they were, could not remove.

Here, then, was a case militating against the views I had held and the doctrine I had preached for many years, viz., that a healthy womb after a normal labor did not have a mischievous clot in it that could not be expelled by its own contractile power, stimulated by external manipulation, rendering it always unnecessary to insert the hand into the organ to turn out the clot, according to the orthodox rule in such cases made and provided.

The case in hand clearly indicated to me the necessity of rendering manual assistance to rid the uterus of the offending clot, and I proceeded promptly to that service. Passing my fingers between the labia, I found the ostium vaginæ closed by a smooth body, seeming to the touch like a ball of considerable dimensions covered with a serous membrane. This puzzled me. In the attempt to obtain knowledge as to its character by a digital exploration of it it was ruptured, and my fingers passed into its substance, solving the mystery of its nature by demonstrating it a clot of blood, of an extent that plugged up the entire vagina and reaching into the womb. Having determined these facts, it was the work of but a moment to break the vaginal coagulum, and, the contracting womb extruding its contents, the whole mass was speedily driven out through the vulva, and the uterus on the instant was reduced to its proper size and position, the pain and distress immediately disappeared, every thing promptly assumed a satisfactory condition, and all was well. The loss of blood had been considerable, but not enough to require further special attention at the moment, nor did it prevent an ordinarily good recovery of the patient.

The outcome of this case declared the correctness of my diagnosis so far as the ultimate facts were concerned, but my views were at fault in supposing the barrier to the exit of the womb-clot to be at the uterine os instead of at the ostium vaginae, where I found it, and the removal of which cleared away the whole difficulty, rendering it not only unnecessary to pass my hand into the womb, but making it obvious that it would have been bad practice to have done so, leaving me at liberty still to declare that in over forty-four years' practice I have never met with a case of post-partum hemorrhage when, to save the life of the patient, it was necessary to pass the hand into the womb and turn out the clot.

This paper is intended as a plea, as was the one on the same subject last year, for a clear comprehension of the nature of post-partum hemorrhage and of the principles which should govern in its management, to the end that the accoucheur, when suddenly brought face to face with the alarming difficulty, shall at once recognize the essential points in the particular case before him, see quickly what ought to be done, and promptly do it, not failing to turn out the clot if such procedure is best, but not feeling that he must pass his hand into every womb when there is hemorrhage after childbirth because such violent proceeding is sometimes necessary. The scientific dogma in this, as in all other therapeutic procedures, should be that the simplest measure that is promptly efficient is the best.

RICHMOND, IND.

ON THE TREATMENT OF CHOLERA INFANTUM.*

BY W. BYFORD RYAN, M. D.

If there be any one theme, among the hundreds that perplex us, which stands pre-eminent in importance, that theme is the treatment of cholera infantum.

Yearly this perilous disorder almost decimates our infantile population, hundreds of homes contributing of their priceless jewels to heap high the ghastly sacrifice to our ignorance and helplessness, while the mortality of every clime suited to its development bears gloomy witness to the inefficiency of our means for its cure.

Of the seventeen hundred children, under five years of age, who died of miasmatic diseases, cholera infantum claimed thirty per centum in this State in the year 1883, and in the same period caused eleven per cent of the total deaths from disease among children under five years of age.

In the city of St. Louis, last year, 9.2 per cent of the total mortality from disease was due to cholera infantum. Of deaths, under five years of age, from all diseases, 23.32 per cent, and from zymotic diseases 40 per cent, were from this cause.

Trousseau, the prince of clinicians, after giving what he regarded as the very best treatment, says: "You must, however, remember that the cases in which recovery takes place are few in number, death being the usual termination of infantile cholera." Dr. Francis Delafield, of New York, declares that treatment of any kind is very unsatisfactory, and insists that the child be given a change of climate if possible, the earlier the better, and this though the prostration be so great that the patient is apparently moribund.

In great cities where people are overcrowded, where heaps of festering filth are constantly accumulating, and where a close, hot, and vitiated atmosphere enervates both old and

*Read before the Indiana State Medical Society, May 13, 1885.

young, the mortality from this disease is simply terrible. Nor are its ravages confined to the poor, the filthy, and the ill-fed denizens of squalid tenement houses; but the children of luxury, in palatial homes, on fashionable avenues, and the rollicking, roseate inhabitants of salubrious farming districts, yield reluctant tribute to this destroyer of the blooming promise of the harvest of our hopes.

It is useless, however, to dwell on the fatality of this affection and the inadequacy of any generally known method of treatment. All acknowledge these, from the greatest to the least, in the profession.

It is not my purpose to discuss the many different theories of the origin of cholera infantum, but rather to call attention to what is apparent to all observers, and, if possible, to draw from my premises a few plain, common-sense conclusions.

You will pardon a brief iteration of the physical condition of a cholera-infantum patient, for, though too familiar to you, it will assist in the development of the theory I desire to present for your consideration.

There is no prodromic period, unless we so regard a laxity of the bowels which is not usually alarming to the family. The invasion is abrupt. The physiognomy of the child quickly undergoes startling, alarming change. In one instance in my own knowledge the change was so rapid and so complete that last summer a father failed to recognize, and could scarcely be convinced that the little sufferer was the babe he left but slightly unwell twelve hours before. The eyes are sunken, and a bluish line is clearly seen beneath the lower lids. The child cries out as if it were being suffocated. The pitch of voice is sharper and higher than usual, resembling the hydrocephalic cry. The skin is cold and almost destitute of tonicity; on being pinched up the fold returns slowly to the normal position. Vomiting is an urgent and distressing symptom. Almost every thing swallowed is ejected within a few moments. In addition to the ingesta, which come up unchanged, the vomited matter is serous fluid and bile. The dejecta, which in the beginning were

lenteric, change to a greenish serum, in which floats shreds and flakes of a green substance generally adhering to the diapers; or the discharge may be of a yellow color, resembling the yolk of egg; but they are *always absolutely serous* and very frequent. As the disease progresses the child falls into a stupor, and lies with the eyes partly closed; there is insatiable thirst throughout, all liquids being swallowed with avidity, regardless of their taste. The abdomen is flaccid and sunken; the skin is dry and of a leaden color. In a word, *the entire peripheral circulation, especially that of the capillary system, is almost nil.*

The causes which lead to this deplorable state are, in my opinion,

I. *The enervating influence of excessive heat, producing, as in Asiatic cholera, spasm of the peripheral arterioles.*

II. *Hyperemia of the gastro-intestinal apparatus*, produced (a) by chilly nights following excessively warm days, and (b) by the reflux of blood from the emptying of the surface capillaries.

III. The vulnerability of the gastro-intestinal viscera in the young generally, and especially in those whose digestive organs are enfeebled by premature weaning or by improper food.

Spasm of the arterioles, or what amounts to the same, paralysis of the trophic nerves, produces peripheral anemia. The congestive influence of chilly nights, added to the emptying of superficial vessels, favors engorgement of the internal vascular system. The atonic condition of the digestive organs, made more vulnerable by premature weaning or improper food, also invites the fugitive blood. *Atonic vessels long distended permit the rapid endosmosis of the serum of the blood.* Hence, vomiting, diarrhea, *serous* ejecta, anemia, excess of fibrin and solids in the blood, and the coagulability of the blood itself, *thrombi* and *emboli*, the plugging of cerebral vessels; hence, death—if, indeed, death do not claim his victim previous to the formation and lodgment of a clot.

If this view of the causes and pathology of cholera infantum

be correct, the rational treatment must necessarily be in direct antagonism to the dictum of Hahnemann, and in full accord with its antipode, *contraria contrariis*, which is, (a) *To restore the blood-supply to the surface, thereby relieving measurably the visceral engorgement.* (b) *To establish and maintain capillary action of the entire economy,* thus arresting extravasation of serum with all its attendant evils. (c) *To give tone to the muscular and mucous coats of the bowel.* (d) *To supply proper nutriment.*

These are the indications; can they be satisfactorily met?

I answer, unequivocally, they can; and, since I have demonstrated practically what I had builded in theory and subjected to the crucial test by brother practitioners, I have felt impelled to shout "*Eureka!*" in every assembly of medical men to which I have gone for the past five years.

Nor yet have I any new drug to present which possesses the powers requisite for the prosecution of a successful warfare against cholera infantum—nor any nostrum or formula even; but an old weapon (a two-edged sword) with which all are familiar, yet one, so far as I know, not before used as a remedy in this affection. The agent to which I refer is the *atropia belladonna*, which I regard as the remedy *par excellence*, the specific and prime factor about which all other remedial measures should circle as auxiliary—important and useful, but altogether secondary.

Having come to conclusions satisfactory to myself as to the etiology of infantile cholera, I cast about me for rational means with which to combat existing conditions.

We find peripheral anemia; belladonna is the most potential means for flushing the superficial capillaries.

We find the vascular system of the intestines and stomach engorged and sieve-like, permitting liquor sanguinis to escape into the lumen of the viscus; belladonna produces dryness of mucous membranes.

We find extreme irritability of stomach and intestines, giving rise to vomiting and excessive diarrhea; belladonna produces partial anesthesia of these mucous surfaces and promptly relieves this condition.

We find progressive anemia, produced by endosmosis of serum; belladonna arrests the waste immediately.

Finally, basing the assertion upon actual experiment by myself and those upon whom I have, with the earnestness of positive conviction, pressed the importance of its administration, I can safely say that belladonna will, in every case, arrest both the vomiting and the diarrhea at once, and that no child sick of this dread summer complaint, who has a fair constitution, need be lost if it have this treatment combined with and followed by such tonic measures and nourishment as will suggest themselves to any intelligent physician.

Minute doses of *nux vomica* and arsenic I regard almost as essential as tonic treatment. I refrain from suggesting formulæ, but can not close my remarks without protesting against the use of mercurials in a disorder where there is no lack of bile secretion, and where the blood is being rapidly broken down without the help of agents which produce that effect.

I should be glad if such of my hearers as may be called on to treat either one of the several choleras would give belladonna a full trial, and report results either in the *AMERICAN PRACTITIONER* or *Indiana Medical Journal*.

WILLOW BRANCH, IND.

Reviews.

Modern Therapeutics : A Compendium of Recent Formulæ and Specific Therapeutic Directions. By GEORGE H. NAPHYES, A. M., M. D., etc., edited by JOSEPH F. EDWARDS, M. D., and D. G. BRINTON, M. D. Eighth edition, enlarged and revised. Philadelphia : D. G. Brinton. 1885.

This original and popular work of Dr. Napheys, revised and made to embody the results of recent study, thought, and experience in the department of curative medicine, is an important issue of the year, and will find many appreciative readers.

A Pharmacopeia for the Treatment of Diseases of the Larynx, Pharynx, and Nasal Passages. By GEORGE MOREWOOD LEFFERTS, A. M., M. D., etc. Second edition, revised and enlarged. New York and London : G. P. Putnam's Sons. 1884. Cloth, \$1.00.

This is a convenient book for the general practitioner, who may not be able to find in the standard works at his command the latest and most approved formulæ for the exhibition of medicaments to the nasal passages and throat. The book, although in the main a compilation from many sources, has the stamp of originality in that it embodies the fruits of Dr. Leffert's ripe experience.

Elements of Surgical Diagnosis. By A. PEARCE GOULD, M. S., M. B., London, etc. Philadelphia : Henry C. Lea's Son & Co.

Several attempts have been recently made in our country and in England to embody the points and principles of surgical diagnosis in separate treatises. In the opinion of some practical surgeons, the success of these ventures is doubtful. Of

the present work, it may be said that it is worthy to rank with the fellows of its class, if it does not possess some features of superiority over these. It is accurate in statement, philosophical in plan, and comprehensive in scope. If it fails of its purpose, the fault is to be looked for in the unwieldy proportions of the subject, and not in the author.

Transactions of the American Dermatological Association.

Eighth Annual Meeting, held at Highland Falls, near West Point, New York, August 27-29, 1884. New York, 1884. 8vo, pp. 26.

The papers read at this meeting have already been given to the profession through the medium of the medical journals. The Secretary's Report presents these in the form of abstracts, with accompanying discussions.

The published proceedings give evidence of a full attendance, much good work, and some substantial advance in dermatological science.

The Physician's Pocket Day-Book. Designed by HENRY LEONARD, M. A., M. D. Price \$1.00. Detroit, Mich.: Illustrated Medical Journal Company.

This call-book was brought out by Dr. Leonard several years ago, and has become deservedly popular. It is designed for a record of the physician's daily work, for charges made, and the credit of cash received. By a peculiar arrangement of the lines and headings the keeping of accounts is made easy, and the physician of moderate practice will need no other book for this purpose.

A Manual of the Medical Botany of North America. By LAURENCE JOHNSON, A. M., M. D., etc. New York: William Wood & Co. 1884. (Wood's Library.)

This is a work of beauty and great practical worth. It is the first treatise upon the subject which can be said to meet the needs of the student as a text-book.

The work is elementary. It begins with a chapter upon general botany, which is followed by a glossary of technical terms, after which every indigenous plant of reputed medical worth is treated by the author briefly, but at sufficient length to make plain its botanical features and therapeutic uses. The book is freely illustrated with well made wood-cuts and elegant chromolithographic plates.

Experimental Researches on Cicatrization in Blood-vessels after Ligature. By N. SENN, M. D. Reprinted from the Transactions of the American Surgical Association. Vol. 2. 1884. Philadelphia: Collins, Printer. 1885.

This brochure embodies the results of a careful study of the literature of the subject, and some fifty-four experiments by the author. His conclusions are as follows:

1. All operations on blood-vessels should be done under anti-septic precautions.
2. The aseptic catgut ligature is the safest and most reliable agent in securing provisional and definitive closure of blood-vessels.
3. A thrombus after ligature is an accidental formation which never undergoes organization and takes no active part in the obliteration of a vessel.
4. The intra-vascular or definitive cicatrix is the exclusive product of connective tissue and endothelial proliferation.
5. Permanent obliteration in arteries takes place in from four to seven days, in veins from three to four days.
6. In ligating vessels in aseptic wounds the vessel sheath can be opened freely without compromising the integrity of the vessel tunics, and such procedure renders the operation safer and easier of execution.
7. The double aseptic catgut ligature should be preferred to the single ligature in ligating large arteries in their continuity near a collateral branch, and should always be employed in operations of tying varicose veins in their continuity as the safest and most effective measure in producing definitive obliteration.

Pyuria, or Pus in the Urine, and Its Treatment. By Dr. ROBERT ALTZMANN. Translated by permission by Dr. WALTER B. PLATT. New York: D. Appleton & Co. 1884.

This monograph is characteristic of its able and scholarly author. In it he treats the difficult question of locating the source of pus which may find its way into the urine in a full and satisfactory manner.

His therapeutics, judged by his reported brilliant results, are admirable.

He believes in local measures alone in the treatment of all inflammation of the tract below the kidney and ureters, giving the preference to weak solutions, and deprecates in any case large dosing with copaiba and drugs of its class, believing that these agents, long continued, are competent to engender renal inflammation. His remarks upon the parasitic nature of certain purulent affections of the genito-urinary tract are very full and clear, though he would seem to attach too much importance to the casts of micrococci and plugs of pus corpuscles as diagnostic signs in pyelo-nephritis.

The chapter upon gonorrhea, contains many valuable suggestions.

The work is liberally illustrated with figures of microscopic views, and of the instruments needed in the treatment of genito-urinary affections.

Clinic of the Month.

THE USE AND ABUSE OF THE TAMPON IN ABORTION.—In a paper on this subject read by J. W. Keene, M. D., before the Buffalo Obstetrical Society (New York Medical Journal), he summarizes his observations as follows:

That the tampon is to be used as a last resort, and only where the hemorrhage is dangerous or the abortion clearly inevitable. We have, moreover, the observation of so experienced an obstetrician as Schröder that the hemorrhage of abortion is seldom dangerous and scarcely ever fatal—a view which Lusk seems to share. It seems enough has been said to indicate plainly that the routine practice of plugging, in threatened abortion with but slight hemorrhage, merely as a precautionary proceeding, has no countenance from the authorities. Practitioners' views as to when hemorrhage becomes dangerous, or as to when an abortion is inevitable, naturally vary. We have seen that it is upon these points only that the authors cited fail to agree.

Besides the natural bias of the physician's mental make-up—his individual, personal equation—his views will vary as his experience has been large or small. To a beginner, the loss of a slight amount of blood from the uterus of a pregnant woman is fraught with direful forebodings. As his experience widens, hemorrhage will become dangerous less frequently, abortion will take its place under the inevitable class with much less facility, and the tampon will be employed only to fulfill its two legitimate indications.

The young practitioner is not the only offender in the over-free use of the tampon. His older brother may well look to the well-worn grooves in which his practice moves more or less smoothly to discover whether he, too, is not a devotee of the tenet that the fetus has no rights which the physician is bound to respect.

In conclusion of this imperfect exposition of a really important subject, let the axiom be laid down that the tampon is legitimately employed only when for good and sufficient reason it is necessary to terminate gestation.

Dr. R. L. Banta said he had not found the danger of inducing abortion by the use of the tampon so great as Dr. Keene and the authors he cited had stated. He formerly used the tampon if he found a woman losing a thimbleful of blood. Now, if he had plenty of time, he let it flow; but if he was obliged to leave the patient, he tamponed. Much depended on the judgment of the physician; the older he grew the less he would fear hemorrhage.

Dr. Frederick believed the indications for the use of the tampon were as stated by Dr. Keene. He considered the colpeurynter preferable to the old-fashioned tampon, and used it in his practice.

Dr. Ingraham said that if a woman did not flow much he felt at liberty to go away. He did not think that the tampon always produced abortion.

Dr. Stockton had been rather frequently called upon to consider whether or not he would use the tampon. In the paper it had been pretty well stated when it should be used; but the question of using the tampon occurred at other times than those mentioned—for instance, after the escape of the fetus when there was retention of the secundines.

Dr. Hartwig would say that, if the tampon was to be used, the indications for its use had been correctly given. He was of the opinion that the tampon should be given up almost entirely. He had used it in some cases. He fully believed, as Schröder stated, that a woman would not bleed to death from abortion before the fourth month. The old-fashioned tampon would certainly excite uterine contractions, and the same might be said of the colpeurynter if sufficiently dilated to check the hemorrhage. There were, however, other ways of tamponing, as with compressed sponge. Another way is to tampon the cervix through a speculum. He thought he would do the latter

if he tamponed at all. But in hemorrhage during pregnancy, and after the expulsion of the child, he had decidedly come to the conclusion that a tampon was unnecessary, because, if the bleeding was slight, the woman could bear it. Small doses of ergot, or even large doses—which never of themselves produced abortion—would check the bleeding. The life or death of the child ought to be decided with a good deal of probability. If the woman had bled much, and the cervix was patulous, we could be sure that the baby was dead. As a scientific ruling, he would put forth the idea that the tampon should not be used at all. Its real value consisted in exciting uterine contractions.

Dr. Tremaine was very glad to hear these views expressed. He did not practice obstetrics, except in consultation. Some years ago he used to do a great deal of midwifery. He never used a tampon but once, and never would again if he could help it. He thought it one of the most barbarous, unsurgical, and nonsensical things ever invented. Dr. Hartwig had expressed nearly his own ideas. He could not see any possible use for the tampon. He used to see much hemorrhage, and was accustomed to control it by injecting alum-water into the uterus. He had never seen a death from post-partum hemorrhage. When there was much bleeding abortion was sure to occur. About the surest way to bring it on was to give opium.

Dr. Lothrop said that how these gentlemen practiced obstetrics and dealt with abortion in the second and third months without the use of the tampon he did not understand. It was an absolute necessity. He very seldom used it unless the life of the embryo was destroyed. How these gentlemen could see the woman lose such a large amount of blood when they could stop it with a simple plug he did not understand. When he had been compelled to use the tampon it had almost always been from retention of the secundines after the expulsion of the fetus. He could not get along successfully in abortion without the use of the tampon. His way of using a tampon was to pack the vagina with cotton pledgets by means of a Sim's specu-

lum. As for septic infection following the use of the tampon, it had never occurred in his practice. There were two symptoms he looked upon as important in abortion—pain and hemorrhage; and the two things he recommended were opium and a tampon.

Dr. Girard had an opinion on this subject, and was willing to give it for what it was worth. He had had many cases of hemorrhage of this character, and had tried many means to check it. When he found the os partly dilated and the cervix softened he was satisfied of the death of the fetus, and that the best procedure was to bring on rapid contraction and prevent further hemorrhage. He believed the tampon in nearly every case would bring on abortion; so he would not use it while there was any chance that the fetus was alive. If the physician was satisfied that the child was dead he did not see that he could do better than to tampon.

The President said that it was difficult for him to understand the import of the paper. In a general way he inferred that its bearing was against the use of the tampon. He used the tampon himself, and had never yet used it, in more than twenty-six years, when he regretted it. He used the tampon for two purposes: first, in extreme cases, to save life, and more especially to avoid the loss of blood. He thought gentlemen made a mistake when they allowed their patients to bleed one ounce. He would say that no man should undertake to practice obstetrics in this day and age and permit his patient to bleed. If he did not succeed in the use of the tampon it was because he did not use it right. He was certain that in case of violent hemorrhage the only way to control it was to put the patient in Sim's position and pack the vagina so tight that there could be no hemorrhage. If he was called to a case of threatened abortion and found the os open and the fetus not accessible, he would not commence by tamponing it if he lived near by; but if he lived ten miles away he would tampon the woman for her own safety, and he would be pretty sure that on removing the tampon the next day the fetus and secundines would drop into his

hands. After the escape of the fetus and retention of the secundines, his practice would be to remove them if he could. If he could not do so with tolerable ease he would tampon. He would not allow the patient to suffer the loss of four ounces of blood. In reference to ergot, gentlemen might give it, if they pleased, in threatened abortion, with a hope that it would prevent hemorrhage; but they should not rely on it. He had come almost to think it nearly useless. He did believe in the use of the curette in removing detritus, and then brushing over the cavity with Churchill's tincture of iodine; then, if there was any danger of hemorrhage, the vagina should be tamponed.

THE USES OF RESORCIN.—Dr. Asa F. Patee, of Boston, Mass., read in the Section on Practical Medicine at the late meeting of the American Medical Association a paper on the Therapeutical Applications of Resorcin, from which we copy, from the Journal of the American Medical Association, what he says about the value of the drug in practice:

The pure white resublimated resorcin is the only kind that should be used. It comes in the form of shining needles; has a sweetish taste, not altogether unlike benzoate of sodium, with a slightly bitter after-taste. It has no unpleasant accompanying symptoms when introduced into the circulation in moderate doses. My experience emboldens me to say that, of all anti-ferments or antipyretics, this is pre-eminently the best. Children and sensitive women will take this remedy unhesitatingly when they would refuse carbolic acid, salicylic acid, or quinine in solution.

I have used it extensively in various forms of gastric disturbances, as in eructations of gas due to food lying in the stomach and not acted upon by the gastric juice. Also in pain and vomiting from the same cause, and in gastric dilatation. In ulcer of the stomach it is a most efficient remedy, and agreeable to the patient. The stomach may be washed out with a five-per-cent solution, or, if the patient emphatically objects to this unpleasant operation—or other conditions do not favor the introduction of the tube—quite as good results may be accomplished by first cleansing the stomach and bowels with a saline cathartic and then administering five grains of resorcin in an ounce of water every hour until six doses have been taken.

In catarrh of the stomach, and in the chronic gastric catarrh of drunkards, this is excellent; it breaks up the thick tenacious mass which coats the mucous membranes. In chronic intestinal catarrh this cures by preventing the fermentation of food, if taken in doses of five grains to the ounce of water before meals; also in flatulence of the bowels from the same cause.

It will prove a most satisfactory remedy in the abdominal pains and feverish condition of children resulting from improper food, and also in acute and chronic diarrhea of children. Its lack of irritant qualities, no less than its anti-fermentative properties, gives it a specific value. It is equally serviceable in the diarrhea of adult life. For the same reason it will act favorably in hypochondriasis, and in the depression of spirits dependent upon liver derangements, and in the numerous forms of "stomach headache," including "sick headache" when of stomachic origin. It is also valuable in gout, chronic rheumatism and lumbago, which, there can be no doubt, are of fermentative origin.

In all pyrexæ resorcin may be employed with benefit, but particularly in intermittent and relapsing fever. It will quickly reduce the temperature, render the pulse slower and firmer, lessen the frequency of the respiration, and promote perspiration. Under its effect the brain becomes clearer, the intense headache is lessened, and the tongue becomes soft and moist. It kills the fibrilla of fever, whether of the intermittent or miliary type. In typhoid fever this remedy is used more for the purpose of producing an aseptic condition of the intestinal canal, but in moderate doses it will keep the temperature within safe limits. It is preferable to salicylic acid because it is less irritating, and has no depressing effect upon the heart. It may be given both subcutaneously and by the stomach.

In pelvic cellulitis, when the temperature is high, resorcin will be found beneficial, and will tend to promote a condition of quietude and sleep.

It is valuable in all stages of pyemia and septicemia.

The antiseptic action of resorcin upon the mucous membranes in chronic nasal catarrh and in chronic bronchitis is very happy. It will relieve the cough of a common cold produced by irritation and inflammation of the air-passages from a collection of mucus.

In whooping-cough it will at once arrest the paroxysms of coughing if a fifty-per-cent solution is sprayed upon the larynx, and if this application is kept up every two hours it will remove it altogether. Whooping-cough is undoubtedly of germ origin.

The action of resorcin as a local application to the mucous mem-

branes is by no means enhanced by using it strong enough to produce vesication. I have found a fifty-per-cent solution to do much better in ulcerated sore throat than the crystals; and sometimes, where there is great tenderness of the parts, the substitution of glycerine in the place of water is still better.

Resorcin is a very good remedy in acute tonsillitis, in eczema of the throat, and in catarrhal irritation of the fauces. I know of nothing better to remove the mucus which coats the membranes of the throat in catarrhal conditions than a one-per-cent solution used as a gargle. And in diphtheria, as a local application to the diphtheritic membrane and surrounding parts, it is valuable; the strength to be from fifty to seventy-five per cent in glycerine. This is the most eligible application, and should be repeated every hour; at the same time let the patient take from thirty to sixty grains during the twenty-four hours.

In varicose ulcers this may be used with the glycerine plasma—one to eight. Carbuncles and boils may also be treated in this manner.

I have had good success in treating bubo with this remedy, by injecting a five-per-cent solution into the abscess and applying the plasma externally. Chancroids heal more readily under the action of resorcin than any other remedy that I have ever used.

In ulcers of the cervix uteri, and in chronic endometritis, and in uterine catarrh, a fifty-per-cent solution should be applied to the mucous lining of the uterine cavity on the cotton-wrapped probe. It is quite as useful in acute vaginitis, and in gonorrhea and inflammation of the urethra in both sexes. Pressed up into the vagina, in the plasma form, it will quickly arrest severe vaginal leucorrhea or gonorrheal discharge.

In obstetrical cases the puerperal symptoms can be arrested by the internal and local use of resorcin. Introduced into the vagina after parturition, its antiseptic action upon the lochial discharge renders it harmless if absorbed into the system.

In hemorrhoids and fistula, and in abscess of the rectum, it is very useful. The abscess and internal hemorrhoids may be treated with resorcin in the suppository form, a manner thoroughly appreciated by all who have had much experience with daily local applications.

In some forms of skin disease I have found it quite beneficial, especially in those which have much redness and burning as their characteristic symptoms, as *acne rosacea* and some forms of *eczema*. It may be used as a lotion, made up of five parts of resorcin to two

parts each of glycerine and water. I have succeeded with this preparation after arsenic, sulphur, and all the other well-known remedies had failed.

Resorcin may sometimes be used upon the skin more advantageously in an ointment made up with vaseline, or simple cerate, thirty grains to the ounce. In making this ointment it is very important that a little water be added to the resorcin, so that it may be broken down into a plastic mass, forming a soft, unctuous compound. This will be found a nice thing for burns, cuts, and bruises where suppuration is threatened or has already appeared.

It is also useful in inflammation of the eye and ear.

I have tried resorcin in all conditions requiring a remedy of its nature, and have not yet been disappointed in its action. Care should be taken to secure the pure article, and judgment exercised as to the proper strength it should be used—all conditions not requiring the same—and also the manner in which it should be administered or applied.

As regards its *internal* action, I know of no remedy possessing its active properties so devoid of all irritating qualities. Even in large doses it may produce toxic but still not dangerous effects.

Externally it may not be considered by some as in any way superior to carbolic acid, but on comparing the two we will find its superiority lies in the fact that it will not cauterize to the extent of carbolic acid, nor produce any of the dangerous systemic effects which local applications of carbolic acid are always liable to produce, in more or less degree, when persistently or extensively used. It is also devoid of the offensive smell which characterizes both carbolic acid and iodoform which fills the atmosphere with an odor which renders the unfortunate bearer an object of suspicion to be scented afar off.

Taking all these things into consideration, I believe that we have in resorcin an antiseptic superior to any yet known.

Proceedings of Societies.

AMERICAN MEDICAL ASSOCIATION.—We take the following brief abstract of the proceedings of the thirty-sixth annual session of this body, held in New Orleans, La., April 28, 29, and 30, and May 1, 1885, from the report given by our valued contemporary, the Medical Record :

The address of the Chairman of the Section in Practical Medicine, Materia Medica, and Physiology was delivered by Dr. H. D. Didama, of Syracuse, New York, who said that a literal compliance with the requirements of the by-laws, that a summary of the progress made in these departments during the past year would subject the Association to a wearisome recital of facts which had already been gathered and widely scattered again through the medium of medical journals. Special attention was directed to only two topics which had most recently engaged the observation of the profession, namely, the comma bacillus and the hydrochlorate of cocaine. The speaker then reviewed the present aspect of the question of the relation which cholera and the comma bacillus sustain to each other, and then referred somewhat extensively to the general subject of bacteriology and the little help it had given to the art of healing. But this negative result, so far as treatment was concerned, did not detract in the least from the value of the discoveries, and the spirit of inquiry should not suffer thereby. Let us labor and wait, and in the meantime direct a little more attention toward prophylaxis and therapeutics. Dr. Didama then reviewed the views of the neurologists who claim that a large proportion of diseases have their origin in disturbance of the nervous centers, and regard fever, rheumatism, etc., as neuroses. He alluded to humoral pathology, in which derangements of the blood were essential factors in etiology, and to the solidists, who pin their faith to cellular pathology. Neither view was absolutely true, and nei-

ther wholly false. Each might be a factor in the origin of disease, and each the last in the circle of etiological causes. The chairman closed his address with a study of the reparative power when disease has invaded, and of the resisting power to the invasion.

The address of the Chairman of the Section in Obstetrics and Diseases of Women was delivered by Dr. R. S. Sutton, of Pittsburgh, Pa. The subject of the address was Ovariectomy. The first part of it was devoted to the history of the conditions surrounding McDowell's first case. The deviations from McDowell's method of performing the operation were then carefully traced up to the present day, and the conclusion reached was that the operation as left by McDowell was almost as complete as at the present time. Two essential improvements were the introduction of the cautery by Baker Brown, and the cutting off of the long ends of the ligature by Nathan R. Smith. Dr. Sutton then showed that from McDowell's operation nearly all the intra-abdominal operations in surgery had sprung, and noted carefully the lectures and papers delivered on the subject during the last twelve months. He insisted, as in all former papers, upon greater care in the surroundings of all intra-abdominal operations, and in further proof of his position pointed to the admirable results obtained by John Homans, of Boston, and Robert Battey, of Rome, Ga., both of whom used the carbolic spray. He stated that for himself he did not use the spray, but looked upon cleanliness and Listerism as linked so closely together that they might be said to be inseparable, for Listerism is the gospel of cleanliness. Mr. Lawson Tait had said to him: "I have sold all my right, title, and interest in Listerism with my tea-kettle to Battey."

Dr. W. C. Van Bibber, of Baltimore, delivered an address containing suggestions in regard to the construction of a health city in Florida, or peninsula and sub-peninsula air and climate, and urged that change of air sometimes permanently arrests pulmonary disease in its first stage, and that the most favorable climate for yielding such a result was one where the tempera-

ture ranged from between 70° and 80° F., provided it is good healthy air. Such a climate can be obtained on the Gulf Coast of the Peninsula of Florida, and if medical, social, and scientific interests would unite at once in the erection of a health city in the locality it could be made so as to have no equal elsewhere.

Dr. Shoemaker, of Philadelphia, protested against the report of the Committee on the International Medical Congress, on the ground that the committee had exceeded its authority; that it had yielded to the threat made by the new-code men at Copenhagen, that unless they were recognized they would use their influence to prevent the Congress from coming to the United States; that a bargain was made, and that men from his own city, who had declared the Medical Association to be a "log-rolling, wire-pulling organization," had been lifted to exalted positions in the proposed official list of the next Congress.

Dr. F. E. Daniel, of Texas, offered the following:

Whereas, At the last meeting of the American Medical Association a committee of seven was appointed to confer with the International Medical Congress, to be held in Copenhagen, with the view to securing the next meeting of that body, in 1887, in Washington, D. C., and for the purpose of arranging for said meeting, and

Whereas, That committee, after having accomplished said object, have proceeded, without authority from this body, to appoint the several officers of sections and committees, which appointments have been published, and thus acquired the color and aspect of an official action of this body, and

Whereas, This Association recognizes said committee as a Committee of Arrangement only, it declines to recognize or accept the said appointments which it has made. Therefore, be it

Resolved, That the Committee on Nominations be instructed to select and present to this body nominees for the office of president and all the other officers of the approaching International Medical Congress.

Dr. J. S. Billings, of Washington, said that all which had been said concerning a threat or a bargain at Copenhagen between the committee and the new-code men was totally and absolutely untrue, that the committee had enlarged itself and

had performed the work it had done, fully believing that it was in conformity with the resolution passed at the last meeting of the American Medical Association, which gave the Executive Committee full power in case the invitation was accepted, to fix the time and to make all special and necessary arrangements for the meeting of the Congress, solicit funds, etc. The committee as enlarged and as originally constituted was composed of men whose honesty of purpose and motives could not with propriety be questioned, and if any mistake had been made or any authority had been overreached, as there might be room for honest difference of opinion concerning the exact power of the committee, it had been unintentional, and did not deserve an unqualified condemnation. Speaking as a member of the American Medical Association, he thought it unwise to condemn absolutely the work which had already been performed by the committee, thereby suggesting that the work of organizing the International Medical Congress could be done by the Committee on Nominations in a single afternoon or at a single meeting.

Dr. Gabriel, of Ohio, was a delegate to Copenhagen, was consulted while there, and thought that the delegates should not have been ignored by the committee.

Dr. Quinby, of New Jersey, thought that the committee had entirely overstepped its authority, not intentionally, only in head and in heart.

Dr. Keller, of Arkansas, regarded the committee as a creation of this Association, to which it should report as successive steps are taken. He offered the following as a substitute for Dr. Daniel's resolution :

Resolved, That the committee appointed by the American Medical Association to arrange for the meeting of the International Medical Congress in 1887 be enlarged by the addition of members from this Association, one from each State and Territory, and from the Army and Navy, and Marine Hospital Service, and the District of Columbia, to be appointed by the present presiding officer, Dr. J. S. Lynch, of Baltimore, First Vice-President, and that this committee, thus enlarged, shall proceed to review, alter, and amend the action of the present committee as they may deem best.

Dr. Keller spoke against placing men in official positions in the organization of the Congress who were in direct opposition to the American Medical Association.

Dr. Cole, of California, said that while the committee had erred, he would not accuse them of having done so deliberately in violation of their judgment. The fact that they had been revered had made them arrogant. He would simply have the enlarged committee, if Dr. Keller's substitute should be adopted, cull the appointments, purify them, and place none in official positions who were not recognized as loyal to the Code of Ethics under which this Association was bound.

Dr. King, of Missouri, believed that while no one should doubt the honesty of the committee, the conclusion could be avoided that it had exceeded its authority. From the work which it had done it would seem that there was no West, no South, and only North and East. Besides, the committee had gone outside and appointed gentlemen who are not members of this Association. He concluded by saying "the specialists of the new-code persuasion should be taken by the top of the head and their throats cut at once."

Dr. Shoemaker repeated that the delegates from this Association to the International Medical Congress were ignored by the committee at Copenhagen, that the new-code men demanded a representation, that they had received recognition, and that they had been ignored.

Dr. Daniel thought that it was not right that the empire of Texas should be ignored as it had.

Dr. Sanders, of Tennessee, said that the committee had placed its construction upon the instructions given by the Association, and that the proposition now was to almost absolutely ignore their honest efforts and adopt a resolution which would emasculate the entire work. He offered as a substitute for Dr. Keller's substitute, a resolution that the Association approves of the action of the committee so far as it has been done, provided that the names of the new-code men are left out.

Dr. Roberts, of Philadelphia, thought if the committee had

exceeded its power, it had been through error, that it was not the duty of the committee to consult the delegates at Copenhagen, and that dissensions and a new order of publication at this state of the arrangements would seriously jeopardize the success of the next Congress.

Dr. Ghent, of Texas, said that it looked as though there was "a bug in the ship somewhere." He favored Dr. Keller's resolution.

Dr. Keller's resolution being in order, Dr. D. E. Bird, of Arkansas, offered an amendment that the States here represented select through their representatives the additional members of the committee, and the present presiding officer appoint for those States and bodies not represented.

Dr. Keller accepted the amendment, and, thus amended, his substitute for Dr. Daniel's resolution was adopted without dissent.

Dr. N. S. Davis reported concerning the subject of the collective investigation of disease in co-operation with the committee of the British Medical Association and the committee of the International Medical Congress. The work has now so extended that a large number of nations have undertaken to perform it regularly, and the committee recommended that work be extended to and performed, as far as possible, by State Medical Societies, and the details of investigation be carried out by means of cards obtained of the Central Committee.

Dr. N. S. Davis, chairman of the committee appointed last year to make some declarative interpretation of certain points in the Code of Ethics, submitted the following report in the form of a preamble and resolutions :

Whereas, Persistent misrepresentations have been and still are being made concerning certain provisions of the Code of Ethics of this Association, by which many in the community, some in the ranks of the profession, are led to believe its provisions exclude persons from professional recognition simply because of difference of opinion or doctrine; therefore, be it

Resolved, That Clause 1, Article IV, in the National Code of Medical Ethics, is not to be interpreted as excluding from professional fel-

lowship, on the ground of difference in doctrine or belief, those who in other respects are entitled to be members of the regular medical profession, neither is there any other article or clause in said Code of Ethics that interferes with the exercise of the most perfect liberality of individual opinion and practice.

Resolved, That it constitutes a voluntary disconnection or withdrawal from the medical profession proper to assume a name indicating to the public a sectarian and exclusive system of practice, or to belong to an association or party antagonistic to the general medical profession.

Resolved, That there is no provision in the National Code of Medical Ethics in any wise inconsistent with the broadest dictates of humanity, and that the article of the Code which relates to consultations can not be correctly interpreted as interdicting, under any circumstances, the rendering of professional services whenever there is pressing or immediate need of them; on the contrary, to promptly meet the emergencies occasioned by disease or accident, and to give the helping hand of assistance without unnecessary delay is a duty fully enjoined on every member of the profession, both by the letter and spirit of the entire Code, but no such emergencies or circumstances can make it necessary or proper to enter into professional consultation with those who have voluntarily disconnected themselves from the regular medical profession in the manner indicated by the preceding resolution.

(Signed),

N. S. DAVIS, Chicago.

A. Y. P. GARNETT, Washington.

H. F. CAMPBELL, Augusta, Ga.

AUSTIN FLINT, SR., New York.

J. B. MURDOCH, Pittsburgh.

This report was adopted unanimously as an interpretation of certain clauses in the Code.

Dr. J. M. Toner read the report of the Committee on Publication, which included the report of the Board of Trustees of the Journal, in which it appeared that at the close of the second year the Journal is free from debt, and that it commands an income which, if not diverted elsewhere, will enable the editor, with his corps of assistants, to make it one of the foremost journals in the land. The total income for the second year was \$21,000, and the total expense, except editorial salary, twelve

thousand odd dollars. The publication of the Journal will be continued in Chicago. Dr. Davis will remain editor, having withdrawn his resignation at the earnest and unanimous request of the Board of Trustees.

In response to repeated calls, Dr. Davis addressed the Association and spoke at some length, concerning the requirements to be met, and the obstacles to be overcome in making a first-class medical journal, all of which could be accomplished by prudence and perseverance.

On motion by Dr. J. M. Toner, of Washington, the report of the committee on erecting a statue of Benjamin Rush was taken from the table and read by the Secretary. The report closed with the following resolution, which was adopted, and the following committee appointed: Drs. A. L. Gihon, of Washington; Henry Smith, of Philadelphia; R. A. Kinloch, of Charleston; S. C. Gordon, of Maine; J. H. Murphy, of Tennessee; M. H. Henry, of New York.

Resolved, That this Association undertake to erect a statue in the city of Washington by members of the profession in the United States, and that the necessary funds be obtained by subscriptions limited to one dollar, and by voluntary donations from such others as may be interested in the matter.

The Secretary announced the following committee on that part of the President's Address relating to Forensic Medicine: Drs. I. N. Quinby, of New Jersey; C. Scott, of Cleveland, O.; W. W. Dawson, of Cincinnati, O.; F. E. Daniel, of Texas; J. V. Shoemaker, of Pennsylvania; Eugene Foster and H. F. Campbell, of Augusta, Ga.

Dr. R. A. Kinloch, Chairman, read the following report of the Committee on Nominations, which was adopted:

President—Dr. William Brodie, Detroit, Mich.

Vice-Presidents—Drs. Samuel Logan, New Orleans; A. Y. P. Garnett, Washington; Charles Alexander, Wisconsin; W. F. Peck, Iowa.

Permanent Secretary—W. A. Atkinson, Philadelphia.

Treasurer—Richard J. Dunglison, Philadelphia.

Librarian—C. H. A. Kleinschmidt, Washington, D. C.

Officers of Sections: Practice of Medicine, James T. Whittaker, Cincinnati, Chairman; B. L. Coleman, Kentucky, Secretary. Section on Obstetrics, S. C. Gordon, Maine, Chairman; J. F. Y. Paine, Texas, Secretary. Section on Surgery and Anatomy, Dr. N. Senn, Milwaukee, Wis., Chairman; H. H. Munn, Missouri, Secretary. Ophthalmology, Otology, Laryngology, Dr. Eugene Smith, Detroit, Mich., Chairman; J. Fulton, Minnesota, Secretary. Diseases of Children, Dr. W. D. Haggard, Tennessee, Chairman; Dr. W. B. Lawrence, Kansas, Secretary. Dental and Oral Surgery, Dr. J. H. Marshall, Illinois, Chairman; Dr. J. E. Baldwin, Illinois, Secretary.

Committee on State Medicine—Dr. J. S. Rauch, Illinois, Chairman; Dr. F. E. Daniel, Texas, Secretary.

Committee on Necrology—Dr. J. M. Toner, Washington, Chairman.

Judicial Council—Dr. R. A. Kinloch, South Carolina; D. D. Sanders, Tennessee; T. G. Richardson, Louisiana; D. A. Ketchum, Alabama; George Beard, West Virginia; J. M. Toner, District of Columbia; A. M. Pollack, Pennsylvania.

Place of Meeting—St. Louis, Mo., on the first Tuesday in May, 1886.

The following members were added to Committee on International Congress: Drs. D. A. Linthicum, Arkansas; George A. Ketchum, Alabama; A. R. Smart, Michigan; J. V. Shoemaker, Pennsylvania; F. A. Sim, Tennessee; J. W. McLaughlin, Texas; A. Y. P. Garnett, District of Columbia; S. C. Gordon, Maine; John S. Lynch, Maryland; Ellsworth Eliot, New York; X. C. Scott, Ohio; W. C. Dabney, Virginia; Nicholas Senn, Wisconsin; Robert Battey, Georgia; J. W. Duprez, Louisiana; W. E. Anthony, Rhode Island; R. D. Murray, Florida; E. P. Cook, Illinois; J. B. Hamilton, Marine Hospital Service; R. B. Cole, California; Charles Denison, Colorado; F. W. Beard, Indiana; D. W. Stormont, Kansas; L. P. Bush, Delaware; A. H. Wilson, Massachusetts; William Pierson, New Jersey; R. A. Kinloch, South Carolina; W. H. Wathen, Kentucky; S. C. Gordon, Maine;

E. French, Minnesota ; N. F. Essig, Missouri ; R. C. Moore, Nebraska ; G. Baird, West Virginia ; Surgeon-General Murray, U. S. Army ; Surgeon-General Gunnell, U. S. Navy.

Dr. Quinby, of Jersey City, offered the following resolution, which was adopted :

Resolved, That the committee appointed in pursuance of a resolution adopted by this Association, April 30, 1885, to constitute an addition to the original committee of seven previously appointed to invite and make arrangements for the meeting of the International Medical Congress, to be held in Washington, D. C., 1887, be and the said committee is hereby authorized and empowered to select a Chairman and Secretary, and to fill all vacancies that may occur by death or inability to attend on the committee, and to appoint the officers of the Congress.

Committee met immediately to make preliminary organization.

Dr. Bulkley, of New York, read a paper on Carbuncle. He objected to incision, because of the danger from pus being absorbed, which does not occur when the carbuncle is allowed to open naturally. He was opposed to poultices, and gave calcium sulphite in quarter-grain doses in gelatine-coated pills every two hours, magnesia sulphate in laxative doses three times a day, and tonic doses of sulphate of iron ; and an application of solid extract of ergot, two drams ; oxide of zinc, one dram ; rosewater ointment, two ounces, upon lint, to the carbuncle, which reduces pain and cuts short the disease.

Dr. Hibberd, of Indianapolis, found that oleate of morphia, applied every two hours, cuts short carbuncle to a few days' duration. He did not incise.

Dr. Lynch, of Baltimore, indorsed Dr. Bulkley's plan, but applied dilute citrine ointment.

Dr. Shoemaker, of Philadelphia, did not incise carbuncle unless there was a considerable quantity of pus. He indorsed Dr. Bulkley's treatment, and did not get good results from oleates.

Dr. Savage, of Tennessee, painted a ring of collodion around the carbuncle with good results.

Dr. Whittaker, of Cincinnati, then read a paper entitled, *An Attempt at Radical Treatment of Tuberculosis*. He had in five cases injected one eighth of a grain of bichloride of mercury into the consolidated portion of the lung daily, in five cases, but without favorable result.

A paper on *The Hypodermic Injection of Oil*, was read by Dr. John V. Shoemaker, of Philadelphia. Experimental and clinical observations have taught us that oils that can not be swallowed or are rejected by the stomach can be absorbed by inunction and subcutaneous injection. Not only has the rapid and good purgative result of oil used hypodermically been demonstrated, but its nutritive action when thus applied has been shown to be valuable in debility, dyspepsia, scrofula, tuberculosis, and in certain diseases of the skin and nervous system. It is the quickest and best method of introducing oil into the system. It is an invaluable means of combating disease, particularly where more nutrition is required, and also for those patients who are either unable to swallow oil, or who can not absorb or assimilate it by the alimentary canal. Oil can be used subcutaneously alone or combined with other suitable agents that can be dissolved in it. It is a valuable menstruum for suspending in it other drugs for hypodermic use. It can be given in connection with a suitable diet, and even with other medication by the mouth, or it can be used alone for alimentation. Oil deposited in this way in the tissues is absorbed, and is no doubt assimilated, and will alone keep up the nutrition of the body. For a purgative action one or two injections of a dram or two of castor oil usually suffices, but for a nutritive effect the same quantity of one of the bland, nourishing oils, *e. g.*, cod-liver or olive oil, should be administered two or three times daily.

In the event that alimentation is depending solely upon the injections, they should be given about every two hours. For the purpose of giving oil hypodermically, a large syringe provided with a needle of good caliber should be used, and the instrument should have a capacity of from two to eight drams. The injec-

tions can be made in almost any part of the body well provided with subcutaneous cellular tissue, into which the oil should always be thoroughly deposited. The points usually selected for the injections are the superior and inferior scapular and sacral regions, on account of the subcutaneous cellular tissue being especially abundant there. Injections can also be made in the arms, the chest front laterally, and back, the buttocks, and the legs. There is more or less irritation at the point of puncture of the skin, about the same as will be seen from almost any other hypodermic injection; sometimes there will also be some attending smarting, with redness and swelling and the formation of a nodular elevation, which usually disappears in from twelve to forty-eight hours; no induration or inflammation follows the injections, provided the usual precautions are observed in using the hypodermic syringe properly, and the tissues in the person receiving it are in the normal condition.

Dr. John B. Roberts, of Philadelphia, read a paper on *False Doctrines in the Treatment of Fractures*, referring first to errors by the invariable use of the primary bandage, and by the use of passive motion too late or too early. He said splints were often left on too long; there was more damage done by letting it alone than by exploring in fractures of the skull. He also referred to fractures of the nose, clavicle, humerus, and elbow-joint. The use of the interosseous pad in the fore-arm, he maintained, did not do what was claimed for it. He believed that as a diagnostic point measurement was not of as much value in the lower extremities as was generally supposed.

Dr. Verity, of Illinois, read a paper on *The Treatment of Compound Fractures by free Drainage and Wiring of Bones*. He claimed that no fragments should be removed unless they were sources of irritation, that all should be wired together and free drainage established. He related several very interesting cases, which he illustrated with drawings.

Dr. Senn, of Milwaukee, Wis., read a paper on *The Surgical Treatment of Cysts of the Pancreas*. The paper was summarized in conclusion as follows: (1) Cysts of the pancreas are true

retention cysts. (2) Cicatricial contraction, or obliteration of the common duct or its branches, and impacted calculi, are the most frequent causes of cysts of the pancreas. (3) A positive diagnosis of a cyst of the pancreas is impossible. A probable diagnosis between it and some other kind of cysts amenable to the same surgical treatment is adequate for all practical purposes. (4) The formation of a pancreatic fistula under antiseptic precautions recommends itself as the safest and most expedient operation in the treatment of cysts of the pancreas.

Dr. William H. Wathen, of Louisville, Ky., read a paper on *The Treatment of the Secundines in Abortion and Labor*. He referred first to the membranes of abortion during the first month, then to those of premature labor, then to those of labor at term. During the first and second months of fetal life the fetus and membranes are so closely connected that one can not be expelled without the other. If the membranes can be removed from the vagina with the finger immediately, this should be done; but if necessary to go inside of the uterus, they should be turned over for a time to nature. The dangers of the third stage are greatest of all.

Medical literature contains many instances of death from retained placenta and membranes.

Dilatation can be made with metallic or rubber dilators, and the membranes should be removed by curette or forceps. A curette can be improvised if not at hand. If the uterus does not expel the placenta in thirty minutes, we should assist it by manipulation. If we forcibly remove the placenta sooner than fifteen minutes after the birth of the child, there is danger of coagulation not being completed.

Dr. Chadwick, of Boston, said that he always asked concerning the previous history of the woman, if she was a bleeder or if she had gone through other abortions with no serious results. If a bleeder, he usually made active interference, fearing hemorrhage, otherwise he waited. In the later months dilatation by the finger was the best.

Dr. Green spoke confirming Dr. Wathen's experience.

Dr. Sinclair, of Boston, favored dilatation by the fingers. He explained the method which he inaugurated several years ago. He inserts one finger, and holds it quiet till the fibers of the uterus are exhausted, then inserts another and then another, occupying in the whole procedure half an hour.

Dr. Carroll, of Covington; Ky., thought the finger not only a good dilator but a good indicator.

Dr. Wathen heartily approved of dilatation by the fingers in the latter months. In the first months he advised instruments.

Dr. C. Fenger, of Chicago, read a paper on Chronic Peri-Uterine Abscess; its Treatment by Laparotomy. If the abscess is deep or behind the uterus, laparotomy is often necessary. He used the thermo-cautery to make the incision. The antiseptic precaution should be employed. He preferred iodoform externally and boracic acid for injections. The advantage of laparotomy over vaginal operation was manifested by the fact that the former gave a better opportunity for reaching the seat of the trouble.

Dr. George J. Engelmann, of St. Louis, spoke of the frequency of the cases and the necessity of recognizing them early, and then using active measures promptly. He thought temporizing caused much evil.

Dr. Gordon, of Maine, thought prophylaxis all-important; half or two thirds of the cases he believed the profession responsible for, especially the young doctors were too free with the uterine sound and nitrate of silver.

Dr. G. C. Reeve, of Dayton, Ohio, reported a number of cases. He thought the young physician not always at fault. If he did suggest the knife, he was discharged and another called.

Dr. Potts said that the best way to evacuate was to dilate along the track of the needle. He agreed with Dr. Gordon in the harm done by the uterine sound.

Dr. Jaggard, of Chicago, spoke of the plan of Dr. Byford to dilate the anus and drain the abscess.

Dr. Sutton reported one case of laparotomy for pelvic abscess, with good recovery.

Dr. George French, of Minneapolis, read a paper on *How Soon after Exposure to Sepsis may the Accoucheur Resume Practice*. He dwelt on the crime of carrying the poison to a patient, and read a number of letters from authorities in England and on the Continent, some asserting time to be essential, others that cleansing and antiseptics was the desideratum.

Dr. Robert Battey, of Rome, Ga., thought a consciousness of the danger of carrying septic matter was one of the greatest safeguards. He believed time or ventilation had something to do with it.

Dr. Hoppler, of Vermont, thought cleanliness godliness itself in obstetrics.

Dr. French believed time salutary, but disinfection more important.

Dr. Henry O. Marcy read a paper on *The Rôle of Bacteria*. He had a number of years ago maintained in the Boston Medical Society that delivery should be carried on with as much antiseptic precaution as an extensive surgical operation. He found then no supporters; now a number of leading schools taught that antiseptic injection should be made in every case as routine practice. In the majority of normal labors there is a solution of continuity, cervical, vaginal, or perineal. The physiological state is so distorted that it was akin to a pathological one. In his own practice he treats the womb as an infecting, suppurating wound.

Dr. French, of Minneapolis, was so entirely in consonance with the views of the writer that he could not criticise.

Dr. Hull, of Arkansas, did not think the essayist correct in considering the uterus as a subcutaneous wound. He thought the state of affairs quite different.

Dr. M. Gordon, of Portland, Me., said that no man was fit to practice medicine who was not clean. He thought every man better off with a bath a day. Hot water was all that was necessary. You can find reports of as many deaths from carbolic-acid and bichlorate poisoning as you can from sepsis in the same time.

Dr. R. Beverley Cole, of San Francisco, Cal., spoke against the ideas expressed in the paper in the strongest terms. He defied any one to show better results in midwifery since the introduction of antiseptics than before.

Dr. A. Reeves Jackson, of Chicago, read a paper on Vaginal Hysterectomy for Cancer. He quoted largely from authorities and tables, and drew the deduction that the mortality was so enormous that the relief gained from the operation was *nil*, and therefore he thought the operation was unjustifiable and should be abandoned.

Dr. E. Zink, of Cincinnati, read a paper entitled Emmet's Operation—when shall it and when shall it not be performed? The doctor went to great labor to compile a paper which treated of the subject in a most thorough and classic manner. He addressed a letter to twenty-five prominent gynecologists in this country and abroad, asking them twelve questions on the subject.

The sum of their answers he presented in tabular form. The number of cases reported operated upon was 4,945, and from the answers to the letters addressed to these gynecologists, from study, reading, and thought on the subject, together with his own experience, he drew a series of conclusions numbering in all twelve. No. 4 was, the operation should never be performed *eo ipso* in cases of simple fissures or lacerations of first or second degree.

Dr. Harvey, of Indiana, opened the discussion. He thought that in many instances the pain was greater in slight tears than in large ones. Large tears eventually cicatrize and do not pain, small tears fissure and become very painful and tender. He likened them to fissure of the anus, and, contrary to Dr. Zink, thought they should be opened and cauterized.

Dr. Wathen, of Louisville, said the doctor had omitted to state the fact that it was sometimes necessary to operate immediately. Every case is an individual one. He thought operation contra-indicated if the case improved under treatment, and contrariwise if sterility or disposition to abortion persisted.

Dr. Gordon, of Maine, said that Dr. Emmet stated that he had never seen a case of epithelioma cervicis without laceration. Dr. Gordon thought every laceration should be operated upon, fearing epithelioma.

Dr. King, of St. Louis, confirmed Dr. Harvey's statement concerning small lacerations, which were more liable to develop cancer than the large ones. He thought Dr. Emmet very inconsistent in regard to operating on small lacerations and regarding the occurrence of epithelioma.

Dr. Aldrich, of Pennsylvania, thought every case should be operated upon. He had seen scratches on the cervix cause much trouble.

Dr. Hale, of Illinois, held the conservative doctrine, yet it was not always the little laceration which should be let alone.

Dr. Healy said that trivial lacerations do not skin over, as had been affirmed.

Dr. Lewis, of New Orleans, had once thought every laceration should be operated upon. With greater experience he has become more conservative.

Dr. H. O. Marcy, of Boston, was glad to hear from gentlemen from all parts of this land, that they were able to diagnose cervical lacerations. Our "masters" across the water are not so expert. He was more conservative now than five years ago.

Dr. Reid, of Ohio, said it had been claimed by the gentlemen that every woman who had had a child had a lacerated cervix. He had seen hundreds of women who had children and no laceration of the cervix.

Dr. Battey was not in favor of operating on every case.

Dr. B. G. Heard, of San Antonio, Tex., read a paper on Intra-peritoneal Adhesions in Relation to Tait's or Battey's Operation. He thought that in many cases when Battey's operation was performed, it was only necessary to open the abdomen and remove the adhesions.

Dr. Battey, in discussing Dr. Gordon's paper, said many considered the field for his operation a very limited one. Sir Spencer Wells had used it but twice, Dr. Duncan but once.

AMERICAN SURGICAL ASSOCIATION.—We make the following abstract, taken from several of our exchanges, of the proceedings of the recent meeting of this Association:

Dr. John B. Roberts, of Philadelphia, read a contribution on *The Field and Limitation of the Operative Surgery of the Human Brain*.

The study of this subject, he remarked in opening, was suggested to him by the observation, while a resident hospital surgeon, of the death of a man from a traumatic cerebral abscess, and the inactive conservative surgery which was then in vogue. "Do we," he asked, "know no better now than to allow a man to die from acute encephalitis without even an attempt at his relief?"

He then introduced nine conclusions which, he remarked, embodied his creed on the subject of traumatic brain injuries:

1. The complexus of symptoms called "compression of the brain" is not due so much to displacing pressure exerted on the brain substance as it is to some form or degree of intracranial inflammation.

Let the profession repudiate the idea, he urged, that displacement of brain substance is the cause of the trouble, and they will then discard many of the erroneous theories in regard to the use of the trephine. There are no definite symptoms by which we can distinguish between an inflammation from laceration and compression of the brain substance. It would be well if the expression, "traumatic compression of the brain" were always translated "traumatic inflammation of the brain."

2. The conversion of a closed (simple) fracture of the cranium into an open (compound) fracture by incision of the scalp is, with the improved methods of treating wounds, attended with very little increased risk to life.

In this respect, the dangers of open fractures over closed fractures of the skull do not correspond to the corresponding fractures of other bones.

3. The removal of portions of the cranium by the trephine or other cutting instruments is, if properly done, attended with but

little more risk to life than amputation of a finger through the shaft of the metacarpal bone.

It remains for the opponents of trephining to show that the cause of death, when it occurs, is due to the trephine. President Briggs and some others consider the operation one of the simplest in surgery; but other authorities oppose that view. The comparison between fractures of the skull and amputation of a metacarpal bone, the speaker considered appropriate, because in each case there was exposed a small amount of cancellous bone tissue. Amputation of the finger may be followed by septicemia and death, and so may the operation of trephining the skull, but neither is to be expected. According to Amidon, the mortality of trephining (3.6 per cent) is less than that of amputation through the shaft of the metacarpal bone (four to five per cent).

4. In the majority of cranial fractures the inner table is more extensively shattered than the outer table. The element of danger in fractures is due solely to the splintering of the internal table. Necrosis of the splintered bone fragments is looked upon by some as the element of danger, but in the opinion of the speaker necrosis is of rare occurrence, and the true element of danger is acute encephalitis that is excited by the splintering.

5. Perforation of the cranium is to be adopted as an exploratory measure almost as often as it is demanded for therapeutic reasons.

This measure the speaker considered justifiable in all cases in which the injury was of sufficient severity to justify the belief that spiculation had occurred.

6. Drainage is more essential in wounds of the brain than in wounds of the other structures.

This method the author believed had been greatly neglected, for surgeons who would be loath to permit an accumulation of pus to remain for an hour after its discovery in any other part of the body, would quietly allow a case to die from an abscess in the brain without an attempt at relief by operative procedure. Several cases were reported illustrative of this proposition.

7. Many regions of the cerebral hemispheres of man may be incised and excised with comparative impunity.

The timidity of surgeons with regard to injuring the brain substance by operative means the speaker attributed to the prevalent ignorance on the subject of cerebral localizations. Deaths are not due to the exposure of the cerebral convolution.

8. Accidental or operative injuries to the cerebral membranes, meningeal arteries, or venous sinuses should be treated as are similar lesions of similar structures in other localities.

Numerous cases have been reported in support of this proposition.

9. The results of the study of cerebral localization are more necessary to the conscientious surgeon than to the neurologist.

The time has come when a man, if he assumes the rôle of a surgeon, must make the study of cerebral localizations a special feature of his education. When called upon to operate in cases of head injury, he must in many cases be the only one to decide what shall or shall not be done.

The principles thus set down were next applied to cranial fractures, to intracranial hemorrhage, to intracranial suppuration, to epilepsy following cranial injury, to insanity following cranial injury, and to cerebral tumors.

The following are the rules adduced by the author:

(a) Cranial Fractures.

Closed (Simple) Fissured Fractures. (1) Where there is no evident depression, and no brain symptoms, no operation should be made. (2) In case of no evident depression, with brain symptoms, incise the scalp and trephine. (3) With evident depression, but no brain symptoms, incise the scalp and possibly trephine. (4) With evident depression and brain symptoms, incise the scalp and trephine.

Closed (Simple) Comminuted Fractures. (5) Where there is no evident depression, and no brain symptoms, it is advised to incise the scalp and probably trephine. (6) In cases of no evident depression, with brain symptoms, incise scalp and tre-

phine. (7) With evident depression, but no brain symptoms, incise scalp and trephine. (8) With evident depression and brain symptoms, incise scalp and trephine.

Open (Compound) Fissured Fractures. (9) In cases with no evident depression, no brain symptoms, no operation is advised, but treat the wound. (10) Cases presenting no evident depression, with brain symptoms, should be trephined. (11) With evident depression, no brain symptoms, possibly trephine. (12) With evident depression and brain symptoms, trephine.

Open (Compound) Comminuted Fractures. (13) If there is no evident depression and no brain symptoms, it is probably proper to trephine. (14) In case of no evident depression, with brain symptoms, trephine. (15) With evident depression and no brain symptoms trephine. (16) With evident depression and brain symptoms trephine.

As a working rule for surgeons the speaker believed that these conclusions would be found reliable and correct. Trephining has become an operation of so little danger that every case of doubt should be treated by it.

(b) *Intracranial Hemorrhage.* Trephine for the removal of a clot and the arrest of bleeding when the probable seat of hemorrhage is ascertainable, and the clot is believed to be a localized one. The speaker then discussed briefly the symptoms which rendered the operation advisable and those which contra-indicated it.

(c) *Intracranial Suppuration.* Trephine and make, if necessary, exploratory punctures in all cases of abscess. This is rendered more compulsory because of the fact that the spontaneous evacuation or other removal of an abscess in the brain practically never occurs. Early symptoms of pus mean, as a rule, "Do not operate;" later appearances of pus indicate, however, the propriety of an early operation. If the pus is not discovered beneath the dura, then incise the dura, and if the pus is not then discovered aspiration should be performed, unless the symptoms disappear upon the removal of tension by the perforation of the dura.

(d) Epilepsy following Cranial Injury.

Remove a portion of the cranium in selected cases.

Abscesses are usually situated in the anterior half of the cerebrum. The symptoms indicating the propriety of trephining in these cases are, a painful or sensitive cicatrix, and symptoms indicating brain irritation in the vicinity of the scar, especially if this be in the anterior half of the cranium. The temperature test was then referred to, and the statement of a modern writer that the temperature may be taken by placing a thermometer in the auditory meatus. The symptoms contra-indicating operative procedure are the presence of signs indicative of inflammatory processes at other portions of the brain, the history of epilepsy or insanity in other members of the family.

In these cases, Dr. Roberts added, several months must elapse before the case can be pronounced one of failure. The operation should be done as promptly as possible.

After a brief review of the last divisions of the application, the author passed to a demonstration upon a chart of the lead-ing cerebral localizations. The rules for these last cases were as follows:

(e) For Insanity following Cranial Injury.

Remove a portion of the cranium in selected cases.

(f) For Cerebral Tumor.

If it can be localized, and if it is probably superficial, remove the bone and excise the growth, if it is found.

Dr. Hunter McGuire, of Richmond, remarked that in reviewing the paper that had just been read, he could find but two instances in which an operation was not advised. This advice, he continued, takes us back one hundred years, to the time when men used to boast of the number of holes they carried in their heads, and when surgeons boasted of the number of heads they had trephined. There are no set rules that can be laid down for the government of all cases; each case must be a law to itself. There are no two injuries to the skull that are the same any more than there are two faces exactly alike.

Referring to the first proposition, he asked how the author could account for the almost immediate appearance of symptoms of compression of the brain in so many cases. A man receives a blow upon the head. The bone is depressed, the brain is compressed, and almost immediately, within a few minutes, or even within a few seconds, symptoms of depression are manifested. Is it possible that an inflammatory exudation could have developed so rapidly? Such, to the speaker, seemed almost impossible. The author has compared the use of the trephine to the amputation of the metacarpal bone. It was either Cooper or Hunter who said that there was to the patient between the trephine and eternity a little thin sheet of paper. How the author came to the conclusion that the application of the trephine was so simple a matter the speaker could not comprehend. He asserts that a man may even be trephined and immediately go to his home. With no disrespect, the speaker wished to know to which home Dr. Roberts referred, and whether it would not in very many cases be the "long home." With regard to the importance of drainage in cerebral difficulties he agreed with Dr. Roberts. In the last case of trephining which he had performed, he had taken out a piece of the scalp of a size to correspond to the size of the trephine, in order to secure thorough drainage. He then narrated several cases in which he had made use of the trephine. In one case, in which an individual had been insane for nine years, the day following the operation he spoke of events as occurring yesterday which had occurred nine years before, and uttered the first coherent words for that period of time.

Dr. Moses Gunn, of Chicago, recalled the position he had taken in a discussion of the same ground covered by this paper three years ago, when he had advocated the early operation in cases of cranial fracture with symptoms of depression, and had endeavored to advocate the rule that in simple or closed fracture the bone should be elevated as in compound fractures, taking the ground that aseptic measures as now practiced avert the danger that would otherwise exist in the conversion of a

simple into a compound fracture. This rule, he thought, if properly applied could be employed not only with safety, but with benefit to the human race.

With regard to the first proposition laid down by Dr. Roberts he agreed, and believed that in many cases the symptoms arise not from depression but from irritation and inflammation. Mere mechanical compression of the brain is not a symptom of importance. As stated by Dr. Briggs, in the discussion referred to as occurring three years ago, if compression of the brain was all that is to be feared, he would never use the trephine, because the brain would soon accommodate itself to the new pressure. The danger is in the changes of nutrition that follow. He did not go so far as Dr. Roberts, however, and say that there are no such symptoms as those of compression. These symptoms, he thought, were too distinctive in their character, and came on too soon after the accident to be due to any other cause. There is then mechanical compression, and not irritation or inflammation; but that mechanical compression does not require the application of the trephine. The danger of permitting the pressure to remain is that it may become permanent and excite irritation and inflammation that may do injury in giving rise to secondary symptoms.

Dr. C. B. Nancrede, of Philadelphia, agreed with the writer of the paper in many points, but differed from him in a number of others. As to the first proposition, he agreed with the previous speaker. If Dr. Roberts were to call it secondary compression, he would agree with him in the conclusion that it is due to some form of inflammation. Compression of the brain produces sudden and violent contraction of the vessels of the brain in the vicinity of the compression. It is an error to associate in our minds the dangers of compound fractures of the cranium and compound fractures of other bones. They are not to be compared. In considering any operation we must consider the complications that may arise from it in the most skilled hands. He could hardly conceive how a serious complication could arise from an amputation of the metacarpal bone, but he

could very easily understand how serious complications could arise from operative procedures upon the skull.

In referring to the fifth conclusion, he remarked that he would be very sorry to have his cranium perforated as an exploratory measure. The importance of drainage he considered well established. On the seventh proposition he differed from Dr. Roberts. Nearly all the cases of operative procedure for brain-tumor have terminated fatally. The treatment of wounds of large arteries and veins, he said, is manifest; but, he added, in all cases where there is reason to suspect that a coronal sinus has been wounded, we should act as though that sinus had been wounded. He was cognizant of one or two cases in which the patient perished before the eyes of the operator because that assumption was not made. In one case which he had seen with Dr. Hopkins, this assumption was made, with the gratifying result of averting what would have been a fatal hemorrhage. As soon as the button of bone was detached, there was a most appalling gush of blood. This was controlled by pressure and the vessel secured by suture, but great difficulty was encountered in the removal of the forceps by which the vessel was secured. Finally a piece of lint, dusted with iodoform, was placed over the ligature and the case went on to recovery.

With regard to the study of cerebral localization, he agreed with Dr. Roberts, and believed that we are now fairly acquainted with the motor centers. There are few of them so well located, however, that we can be sure of the point that should be uncovered. As for the reasons for the application of the trephine he agreed in some of them with the author and differed in others, but considered the subject one that should be given more deliberate investigation. How Dr. Amidon could have obtained such a number of cases with so low a mortality as 3.6 per cent from trephining, he could not understand. From his investigations, he would place the mortality at about ten per cent.

As to the importance of drainage he agreed with Dr. Roberts, but not to such a degree as asserted in the paper. In regard to the temperature test, the speaker referred to its impor-

tance if it could be confirmed. In every case of which he could learn in which a record was taken, where the inflammation was confined to the brain substance itself, the temperature was normal or subnormal. He further cautioned against waiting until inflammation had developed before applying the trephine. After inflammation has developed there is no good that can be done by operative procedures, unless there was a mass of pus to evacuate. The symptoms of intracranial irritation can be recognized long before there is any change but an effusion of serum.

Dr. W. F. Peck, of Davenport, Iowa, said that he coincided, in the majority of instances, with the opinions expressed in the paper. The first thing to decide in accidents to the skull was whether any injury had been done to the brain, and then whether pressure was being exerted upon the intracranial contents. The secondary consequences certainly call for other interference than therapeutic. Several cases were then narrated to illustrate his views on this subject. He had had about six cases, and in their treatment he had endeavored chiefly to remove pressure and to establish drainage, which being secured, the result was as a rule favorable.

Dr. T. F. Prewitt, of St. Louis, considered the propositions of Dr. Roberts so sweeping that they should be thoroughly discussed, and clearly defined views as to the conditions which demand trephining and those which do not demand it laid down. He did not consider the injury in a simple case of fracture as of great importance. The danger is from the injury that may have been done to the brain. There is, however, undoubted danger in a too free use of the trephine. Some fractures of the skull are unaccompanied by symptoms, and are recovered from without leaving any permanent ill-effects, hence it is not proper to use the trephine in all cases. Those cases in which there are very sharp needle-like spicula, are those in which the trephine should be used. Where, then, it is believed from the nature of the injury that the spicula are of this kind, as in perforating wounds, it is proper to trephine, even in the absence of very severe symptoms. Where there were no symp-

toms and no external wound, the speaker thought it proper to wait.

Dr. C. T. Parkes, of Chicago, differed from Dr. Roberts in regard to the symptoms of compression, but admitted that it is difficult to determine to what these symptoms are due.

Dr. S. W. Gross, of Philadelphia, requested that Dr. Roberts explain, before the discussion was permitted to go further, exactly what he meant by the expression "brain symptoms."

Dr. Roberts explained that by the term he meant the manifestations which are generally believed to come from lesions; in cases of fracture the term symptoms is generally employed to designate the coma, the hemiplegia, etc., which are usually attributed to depression of bone, or a clot upon the cerebral cortex. But in his first proposition he had tried to make clear that when we say compression we mean irritation, which is the first symptom of inflammation.

Dr. Prewitt then continued his remarks by a review of the propositions of the author, and a statement of his views upon them. Referring to the location of the center of sensation as given by Dr. Roberts, he narrated a case that had occurred in his practice. A man was struck upon the upper and outer portion of the parietal and anterior portion of the occipital bone with the end of a pistol. There was a complete fracture. He trephined, and noticed that before the operation as well as during it a large amount of brain substance was removed. After trephining, he introduced his finger and found upon the tentorium cerebri the "sight" of the pistol. In this case the seat of sensation must have been lacerated, and in part at least removed, and yet there was not a symptom of the trouble that would be expected to follow. Two weeks later, however, the man had a chill and became hemiplegic. This was found due to the removal of the drainage-tube, and when this was replaced the symptoms soon subsided.

Dr. J. Collins Warren, of Boston, referred to the difficulty of obtaining such thorough drainage as that referred to. This is chiefly on account of the intracranial tension with which we

have to contend. We do not find usually large collections of pus, but get rather the symptoms of irritation from brain-inflammation without much accumulation of its products. Another difficulty in deciding the question of interference in any given case lies in the difficulties of diagnosis. We may also have brain symptoms from lesions external to the brain, as from periostitis and cellulitis. He reported a case of fracture at the upper and anterior portion of the parietal bone, that was treated at the Massachusetts General Hospital, which had been thoroughly analyzed by Dr. Walton, the neurologist of that institution. In that case paralysis of the leg first appeared, then paralysis of the arm, and finally a paralysis of the lower portion of the face. After some time had elapsed the symptoms began to disappear in the order of their invasion.

Dr. L. McLane Tiffany, of Baltimore, differed from Dr. Roberts as to the insignificance of open wounds of the cranium, and remarked that most surgeons preferred to have their wounds, whether of the cranium or of other parts, remain closed. Certain monkeys, he continued, have been cited as having had their heads opened without damage, but it has yet to be shown that any man has had his head opened with as great impunity. In regard to the shattering of the inner table of the skull, he referred to the fact that it only depended upon which direction the missile took which table was shattered. He further called attention to the difference which exists between grown persons and children with regard to operative procedure, and remarked that he had seen a number of fractures in children which had gotten well without any bad symptoms, and in which the groove in the skull could be felt after the individual had reached maturity, but where a similar injury to an adult would have certainly called for operative interference. Attention was also called to a difference between the negro and the white race in regard to these operations. The negro, he said, will tolerate operations involving the brain with much less shock than the white man. He thought that the diagnosis where there were no symptoms and no depression was an impossibility. Lastly, in referring to the

rules laid down by Dr. Roberts, he called attention to the direction, "brain symptoms, but no depression," and asked "How would you know where to trephine?" There might be counter and not direct injury, and for this reason there should be a distinction made.

Dr. S. W. Gross agreed with Dr. Roberts that there might be brain symptoms with no evidence of a fracture. Such an occurrence is of extraordinary frequency in army practice, as he remembered stating in a paper which he had prepared a few years ago on the subject of fractures of the skull in military practice. The dura mater may be so much stripped from the internal table of the skull as to give rise to an effusion of blood, and in such a case the symptoms of compression come on much more slowly than in case of the rupture of a branch of the middle meningeal artery. In regard to the simplicity of open fractures of the skull he differed from the author of the paper chiefly for the reason that the carrying out of the antiseptic precautions in the skull injuries is an exceedingly difficult matter. He did not consider trephining as safe as amputation of the metacarpal bone. The tables of Amidon, he stated, will not bear a critical inspection, for he has made a theory and has made his facts fit his theory, so that his paper is unreliable.

In regard to drainage, he agreed with Dr. Roberts, but added that the drainage of the brain is an exceeding difficult thing to accomplish. In regard to the rules that are laid down, he thought it proper to make further investigation before such measures are adopted. In the case of gunshot injuries, he thought it proper to enlarge the opening and to follow the ball with a large probe until its location is established, and then, if possible, to remove it. The popular sentiment with regard to the interference by the surgeon in cases of cranial injuries was also strongly denounced.

Dr. E. M. Moore, of Rochester, considered the subject one upon which the Association should give a very decided opinion. Accidents to the head are cases that are occurring to us constantly, especially in cases of suicide. What is to be done?

With regard to popular sentiment, he did not think that the scientific surgeon should trouble himself about the silliness of juries or the folly of judges. The idea of using a drainage-tube in the brain is modern, but the good results that have followed its introduction are gratifying. He has been accustomed of late to use a large probe, as recommended by the last speaker, for the exploration of these wounds. In the last case in which he had used it he was able to follow the bullet down to the occipital bone, and then to trephine down upon it and remove it. He did not persevere sufficiently to carry the drainage-tube entirely through the track of the wound, as he now regretted that he did not do. The recovery in many cases is clearly attributable to the free drainage that is established by the wound, or by operation. As for the statistics of trephining, he considered them of no value whatever.

Dr. J. W. S. Gouley, of New York, read a paper on *Some Points in the Surgery of the Hypertrophied Prostate*, from which, in the absence of space for the paper entire, we abstract the following points, which are of great practical interest to every physician:

Physical Exploration. Digital examinations per rectum will give some idea of the size and consistency of the prostate; whether one lobe is larger than the other; if it is nodulated or smooth; and whether it is of normal length or there is longitudinal increase. Other methods of examination are required before a diagnosis is arrived at. Ask the patient to urinate in a standing posture. Some idea of the condition of the prostate may be arrived at from the character of the stream. But a man with a constricted urethra voids his urine in precisely the same manner as a man with an enlarged prostate. The stream flows steadily for a time, then stops, a few drops escape, the stream again flows, then a few drops, then a dribble, and so on. After he has discharged spontaneously all the urine he is able, a soft catheter is introduced, and the residual urine drawn off, measured, and examined chemically and microscopically. It is generally cloudy. Dr. Mercier invented a small rectangular sound, which is of the greatest value. Its chief advantage is in the extreme shortness of its beak, being only seven eighths of an inch in length. Not only the size, but the exact form of the enlargement of the gland

could in many instances be outlined; but for this purpose he had devised an instrument having two bars and possessing many superior qualities, all of which were detailed.

Medical Treatment. The idea of reducing the hypertrophied gland by purely medicinal means had been exploded long ago. Yet the fashionable remedies at the present time are mineral waters. He did not wish to condemn their use, but regretted they too often led to the neglect of other more valuable methods. Remedies can often be employed for the relief of concomitant symptoms and to the improvement of the general health of the individual.

Surgical Treatment. (1) Mechanical means of relief; (2) Removal of the organ by surgical means. All hard catheters should be discarded except in cases of false routes. Among other requirements for a soft catheter was that it should have as small and as smooth an eye as possible, and never two eyes. Small catheters are usually preferred, but too small an instrument should never be used. Where false routes exist, a large catheter should be employed, and where this fails, the invaginated catheter of Mercier is usually successful, but it requires to be used with the greatest care and caution, for, unless the surgeon keeps the male portion of the instrument under perfect control, it may do injury.

Evacuatory Catheterization should be commenced early in each case; but in old cases where the bladder has become distended, it is of the greatest importance that all the urine be not removed at one time. The catheter should be used from twice to five or six times daily. If the catheter be too freely used, many alarming symptoms are relieved and the individual appears to be in a much better condition than before; but at the expiration of a few days the individual begins to show symptoms of disease of the kidneys, which, rapidly increasing in severity, lead to his death at the expiration of a month or six weeks. In some cases there is great difficulty to determine the proper treatment. Without the use of the catheter the individual must succumb; its use is unsafe. Under such circumstances, withdraw but a small part of the residual urine at intervals of once in several days, until tolerance was established. In one case under his observation, the enlarged bladder extending above the umbilicus was mistaken for a hydatid cyst and tapped. After its true nature was discovered, the method of small and infrequent catheterization was adopted, with the effect of producing a toleration. Polyuria is, however, very apt to develop and carry off the patient.

Inject Medicated Fluids into the Bladder in a quantity to correspond to the amount of urine removed. For this a solution of borax was

most employed, but various other agents might be used, as when the urine was strongly alkaline an acid might be added; when large accumulations of mucus and pus were present alkalies were indicated; when phosphates were deposited in the cavity of the bladder he used weak solutions of acetate of potash. Carbolic acid he did not indorse, but considered nitrate of silver, in proper diluted solutions, one of the most valuable agents we possess. Morphia, hyoscyamus, or cocaine may be added in cases of great vesical irritability. Hot and cold water have had their advocates.

Removal of Gland was first done by means of incisions by John Hunter. Caustics have been employed; Dr. Physick, of Philadelphia, dilated the neck of the bladder; others have made compression with a metallic sound. Attempts have been made to ligate the tumor, and some have tried to grasp it and tear it away with Jackson's lithotrite. Mercier devised an instrument for the removal of the prostate in 1838, and since then he has made three modifications—one of incising, and two for excising the tumor. The author calls the instruments respectively, prostatotome and prostatectatome; and the operations prostatotomy and prostatectomy. He claimed priority in such cases of reaching the prostate through the perineum and incising it. This was similar to the operation since described by Harrison.

Dr. S. W. Gross, of Philadelphia, considered the remarks especially proper in the treatment of patients after they have entered upon their "catheter life." He also indorsed the propriety of prostatotomy. There can be no doubt that the operative treatment of enlargement of the median portion of the prostate, giving rise to obstruction of the vesical orifice of the urethra, is capable of great advances. Up to the present date, prostatotomy, as practiced by Mr. Reginald Harrison, fulfills the indication more surely and with less risk to the patient than any operation that has been devised. In an old man, that surgeon opened the membranous urethra through the perineum. The obstruction was then divided, partly with a probe-pointed knife and partly by divulsion with the finger, and the edges kept apart for eight weeks by means of a large tube, through which a smaller tube was passed to conduct off the urine. The patient was able to go about in ten days. On withdrawing the tube, a large bougie was passed regularly until the perineal wound closed. All obstacle to normal micturition was overcome; the urine was passed every few hours, and the bladder was completely emptied. At the end of six months the patient had a paralytic seizure, but there was no necessity for a resort to the catheter. The case was a

most unfavorable one for the operation, but the result was most brilliant. Through the small perineal wound the nature of the obstruction was accurately determined, and the incision was made with a degree of accuracy and safety which can not be obtained with Mercier's cutting instrument passed through the urethra. In the *Gazetta degli Ospitali*, for February 11, 1885, he found that Professor Bottini, of Pavia, has successfully operated on a similar case with the thermo-cautery applied to the median portion for forty-five seconds. A catheter was retained in the bladder for four days, when it was removed, and the bladder emptied every six hours. The first natural emission of urine took place on the twenty-fourth day. In three months micturition was normal, and the urine was clear and acid; three months and a half later the patient was fully restored to health. As in the operation of Mercier, there is no certainty in operation through the urethra with the thermo-cautery; and the great tendency of cicatricial tissue after burns to undergo undue contraction makes it a matter of grave doubt whether the improvement will be permanent. Hence the operation of Harrison is the better one, and is entitled to extended trial.

Dr. N. Senn, of Milwaukee, read a paper entitled an Experimental and Clinical Study of Air Embolism, of which the following is a *résumé*:

1. The presence of adventitious air in the vascular system during life gives rise to air embolism.
2. Each air embolus constitutes a mechanical source of partial or complete obstruction to the flow of blood in the vessel in which it is located.
3. Aspiration during the inspiratory movements of the chest is the direct or exciting cause of ingress of air into a wounded vein or sinus.
4. Elevation of the head is the sole predisposing cause of the entrance of air in wounds of the superior longitudinal sinus.
5. In veins the predisposing causes consist in:
 - (a) Elevation of the part wounded; (b) Pathological or anatomical conditions which prevent collapse of the vein when it is wounded.
6. Insufflation of a fatal quantity of air into a vein produces death by:
 - (a) Mechanical overdistension of the right ventricle of the heart, and paralysis in the diastole; (b) Asphyxia from obstruction to the

pulmonary circulation consequent upon embolism of the pulmonary artery.

7. Insufflation of the same quantity of air into arteries is less dangerous than when introduced into veins. When death is produced in this manner it results from :

(a) Acute cerebral ischemia; (b) Secondary venous air embolism; (c) Intense collateral engorgement of the vessels of the brain and spinal cord, the manner of death being determined by the amount of air injected, and the direction in which the injection is thrown, as well as the time which has elapsed between the operation and the fatal termination.

8. Air injected into the arteries is really forced through the systemic capillaries into the venous circulation and right side of the heart by the powerful contraction of the left ventricle.

9. Air embolism of the pulmonary artery is relieved in a comparatively short time, provided the contractions of the right ventricle continue unimpaired for a sufficient length of time to force the air through the pulmonary capillaries into the general circulation.

10. The prophylactic treatment consists in proximal or double compression, or ligation, of the vein which is endangered by the operation.

11. The indirect treatment has for its objects :

(a) The prevention of the admission of air; (b) The administration by inhalation or hypodermic injection of cardiac stimulants; (c) Venesection.

12. The direct or operative treatment by :

(a) Puncture and aspiration of the right ventricle; (d) Catheterization and aspiration of the right auricle, which is proposed with a view to obviate the direct cause of death by the removal of air and spumous blood, thus relieving directly the overdistension of the right ventricle, and at the same time to guard against a fatal embolism of the pulmonary artery.

13. The results obtained by experiments upon animals warrant the adoption of the operative treatment of air embolism in practice, as a last resort, in all cases where the indirect treatment has proven inadequate to meet the urgent indications.

Notes and Queries.

THE tardiness in the issue of the present number of the PRACTITIONER is due to the very serious and protracted illness of the Editor, who, after ten weeks in bed, is just beginning to be able to give some thought to his work. The June number will appear on time.

UNIVERSITY OF LOUISVILLE, MEDICAL DEPARTMENT.—The following changes have recently occurred in this institution. Dr. Holland having accepted the chair of Medical Chemistry and Toxicology in the Jefferson Medical College, Philadelphia, Dr. Octerlony has been transferred from the chair of Obstetrics and Diseases of Women to that of the Theory and Practice of Medicine previously occupied by Dr. Holland. Dr. Turner Anderson has been transferred from the chair of Materia-Medica and Therapeutics to that of Obstetrics and Diseases of Women. William Bailey, A. M., M. D., for the past thirteen years professor of the Theory and Practice of Medicine in the Louisville Hospital Medical College, and President of its Faculty, has resigned his place in that institution and been appointed to the chair of Materia-Medica and Therapeutics in the University.

Prof. Bailey is too well known to the profession to need any introduction here. He was a most acceptable teacher in the college with which he was so long connected, and of course he will prove equally so to the University classes. He is a most pleasing lecturer, and a practitioner of high standing and large experience.

When Prof. Holland's resignation reached the Board of Trustees of the University, the following resolution of regret was unanimously adopted:

Prof. J. W. Holland, M. D., having resigned his chair in the University of Louisville, in anticipation of removal to Philadelphia, the President and Trustees of the University accept with regret his

resignation, which severs a connection with the Medical Department extending through sixteen years. He was elected a professor in our school at a most important time in its history, assuming the position at an age when such responsibility is rarely conferred, but to which his talents and learning entitled him. During the long period that he has lectured in the University, Prof. Holland has continually added to his fame, and he is known to the profession of medicine throughout the country as a lecturer of rare eloquence, and a teacher of profound learning. In giving him up, the University loses one of its most valuable and highly esteemed professors. We extend to Prof. Holland, in parting with him, our sincere wishes for his success in his new field of labor.

Prof. Holland's colleagues share with the Trustees their regret at losing their gifted and pleasant friend. It is to be hoped that the managers of the Jefferson Medical College will look, hereafter, elsewhere than to the University for its supply of teachers. Twenty odd years ago they took Dr. Gross away; two years ago they persuaded Dr. Parvin to give up his place here, and now they have laid hands on Dr. Holland. Naturally the University feels the compliment, but it has had compliment enough for a season.

Three of the present Faculty of the Jefferson Medical College have been drawn from the West—from Kentucky and its immediate neighborhood—Drs. Parvin, Holland, and Bartholow—the latter drafted from Cincinnati, and none the less brilliant as a teacher than his associates.

MEDICAL LEGISLATION.—The annual address before the Association of American Medical Editors was delivered by the President, Dr. H. O. Marcy, of Boston, Mass. He chose as his subject that important and much-vexed theme, Medical Legislation. We reprint the address as a supplement. Its very able author treats the subject in a manner which can not fail to impress all thoughtful readers.

CONCENTRATED FOODS OF AMERICAN MANUFACTURE.—It has been pleasant to note, as readers of medical journals have been able to do for some years past, the rapid headway

which pharmacal preparations of American manufacture have made among the profession in Great Britain. Seven or eight years ago the writer chanced to be in London at a time when the makers of lacto-peptine were endeavoring to put this very useful combination into the hands of the profession of that city. It soon acquired a large sale and gave great satisfaction, and it certainly is a very valuable helper of digestion. Along about the same time the several extracts and combinations made from malt began to assert themselves as of much worth as foods and digesters of food. Various and important have been the changes and improvements and "betterments," as the builders say, in malt and its derivatives since that day, until now they come to us as concentrated foods of the very highest therapeutic value. Among the most recent notices of maltine of American make is one contained in a late number of the *Midland Medical Journal*, one of the best of English periodicals. We make room for a portion of it:

One of the most effective combinations in dyspepsia, cholera infantum, and all diseases resulting from imperfect nutrition is maltine with pepsin and pancreatine, containing, as it does, three of the all-important digestive agents, diastase being one of the constituents of maltine. Dyspepsia in most cases will be found to yield to the medicinal properties of this combination, while the system is invigorated by its nutritive qualities. It will be found a useful remedy also for constipation and chronic diarrhea resulting from mal-nutrition. Not only is maltine of itself of great value in certain cases, but it may be combined with the most valuable alteratives known—such as iodides, bromides, and chlorides, and is found to be a remedy of high value in all depraved conditions of the blood. Manufactured by the Maltine Manufacturing Company, of New York. Prof. Tichborne, after an examination of the principal unfermented extracts of malt in the market, finds that maltine manufactured by the Maltine Manufacturing Company, of New York, is the richest in two of the most important ingredients in these foods, namely, the phosphates or bone-formers, and that peculiar

farinaceous digestive agent called diastase. Maltine may be said to consist of about eighty per cent of pure food in its most concentrated and assimilable form. This eighty per cent may be divided as follows: five and a half per cent of flesh-formers; seven per cent of heat-givers; two per cent of bone-formers; add to this the diastase, which imparts to it the curious power of digesting all farinaceous food outside itself, and we have in maltine a most valuable adjunct to our invalid diet. In respect to the diastase, maltine seems remarkably energetic, and at the temperature of the human body one part liquefied "twenty parts of starch in two minutes," and had completely changed or digested that body in about an hour. Maltine possesses all the characteristics of a cereal extract as prepared from the grain, and there can be no question about the genuineness of this preparation. It is only necessary to consult any work upon dietetics to see that there is considerable difference in the composition of the various grain crops. By combining these three important substances—barley, oats, and wheat—a food is obtained which represents the average composition of the three cereals, and that food already digested for use, a condition of immense value to the physician in those special cases where the digestive functions are impaired.

One of the latest honors won by American pharmacy was for this particular preparation of maltine, and came in the shape of a gold medal from the Health Exhibition of London.

STATE MEDICAL SOCIETY OF LOUISIANA.—At the annual meeting, held in New Orleans in April, the following officers were elected for the ensuing year: President, Dr. Sam'l Logan, of New Orleans. Vice-Presidents, Dr. E. S. Lewis, Dr. C. J. Bickham, Dr. T. J. Woolf, Dr. A. A. Lyon, Dr. Wm. Kelly, Dr. O. P. Langworthy. Annual Orator, Dr. H. D. Bruns. Place of meeting, New Iberia; time, April.

THE GEORGIA STATE MEDICAL ASSOCIATION at its last meeting selected the Atlanta Medical and Surgical Journal as the official journal of the Association. The following officers were

elected: R. J. Nunn, Savannah, President; L. B. Alexander, Forsyth, First Vice-President; T. F. Walker, Cochran, Second Vice-President; Dr. James D. Cray, of Atlanta, Secretary. The next place of meeting will be Augusta.

THE MEDICAL ASSOCIATION OF ALABAMA held its annual session at Greenville, in April. The following officers for the ensuing year were elected: D. F. M. Peterson, of Greensboro, President; Dr. Star, of Wilcox County, and Dr. Richard M. Fletcher, of Madison County, Vice-Presidents. The Association will meet at Anniston next year.

TENNESSEE STATE MEDICAL SOCIETY.—At the recent meeting, held at Nashville, the following officers were elected for the ensuing year: President, Dr. Thomas L. Maddin, of Nashville; Secretary, Dr. C. C. Fite, of Nashville; Treasurer, Dr. Deering J. Roberts, of Nashville.

DR. J. J. SPEED died at his home, in this city, on the morning of May 6th, in the sixty-eighth year of his age.

For many years past Dr. Speed occupied the chair of Institutes of Medicine and Public Hygiene in the Louisville Hospital Medical College. He was an impressive teacher, beloved both by his colleagues and the students he taught. He was a sagacious practitioner, a true friend, an amiable gentleman, a useful citizen, and his loss will be very extensively deplored. His health, long feeble, gave way at last under some renal complication.

DR. J. S. BEMISS died at his home, in Cannelton, Indiana, a few weeks ago, aged forty-seven years. He graduated from the University of Louisville in 1861. Soon after he entered the Confederate army, was at once given the rank of surgeon, and served throughout the war in a manner to win friends in all branches of the service.

After the war was ended, he located at Cannelton, where, in due time, he acquired a large practice, and more than ordinary weight and influence with the public at large.